

# **Educational relationships: A study in midwifery**

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### **Abstract**

At its inception in 1902, formal midwifery training developed within hospital midwifery services. With the development of a theoretical base, training became education during the 1980s. During a period of economic and societal changes in the 1990s, midwifery education was incorporated into higher education, separating education from health service practice. There were consequences for midwifery education especially the structure of pedagogical relationships.

This thesis looks at key sets of relationships in midwifery education between the three main groups of actors: academics, clinicians and students. In so doing, the inquiry utilises a grounded theory approach and embraces disciplines of education, social sciences, social psychology, management and philosophy. The study confirms the importance of relationships between the key actors as part of a student's learning experiences. However, these relationships have become more problematic as a result of the organisational separation between the academic and professional components.

A framework is proposed to describe educational relationships in midwifery. The framework has six dimensions; (i) a core component of personal traits, (ii) a secondary component of social and communication abilities and four subsidiary components of (iii) professional expertise, (iv) personal knowledge, (v) education knowledge and skills and (vi) a vision for practice. Realisation of the components by one person of another within the three groups aids mutuality in understanding. General principles are offered that include notions of encounter, exchange, rules, boundaries, reciprocity and reinforcement that aid in constructions of relationships.

Though these conditions, in themselves, aid the formation of learning relationships, two processes occur in these relationships through encounters, that is, complementation (a unity of meanings between actors) and complementarity (a matching of understandings). These require a forum for encounters. A model of education is proposed that offers just such a forum aiding positive encounters to promote learning between the three groups of actors. Features of this model are the development of teachers within clinical practice, accreditation of practitioners as educators and the education of students primarily in clinical situations with interactive learning.

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# **1 The context of midwifery education**

## **Introduction**

Until recently formal preparation for midwifery was conducted in midwifery schools in the health service. In the last decade, midwifery education has been integrated within higher education, but with formal agreements for training in practice being established with the health service. This study is concerned with relationships between students and their educators across these two public service institutions.

The health service has recently undergone major changes in its organisation, with alterations to its structure, resulting in multiple lines of communication and relationships between the professional groups. The following issues influence the environments within which students learning and their relationships take place. A combination of economic forces and marketisation (Bagguley, 1994) has increased flexibility in both working patterns and delivery of care within the organisation (Burrows and Loader, 1994). This is evidenced by changes in management structures, with reduced hierarchical lines and flatter structures (Burrows and Loader, 1994). Varied work patterns in midwifery include an increase of part-time working and flexible shift patterns of work. Reduced hospital lengths of stay,

increasing community care and alternative modes of delivery of care have meant that many midwives work in teams, in hospitals and in the community (Stock and Wraight, 1993). The latter working patterns are identified in current Government Reports (Great Britain, 1997a; Department of Health, 1999a).

There is a continuing evolution of scientific knowledge and information technology within the health service. The profession has felt a sense of instability with these changes over the last two decades. Alterations of the control mechanisms of the Department of Health (Stock and Wraight, 1993; Great Britain, 1997a; Great Britain, 1992), together with emergent self-governing trusts and new health authorities, have increased administration. There are fiscal restraints. New control mechanisms are now promoted such as clinical governance (Great Britain, 1997a; Department of Health, 1992b). Flexibility within the health service has also created new patterns of delivery of care with a combination of more centralised control from government departments and tightening policy regimes resulting from an imposition of fiscal policies.

Changes in higher education have also resulted from market forces (Rustin, 1994). Social movements in society require an individual to be self-reliant. Having opened its doors to wider participation (Scott, 1997), higher education has expanded to produce courses that meet the requirements of industry and the world of work. There is an emphasis on competence as an outcome of programmes to



meet the demands of employers. Innovations, with modular development, cross-discipline courses, and an increase in vocational programmes (Rustin, 1994), have had an impact on the delivery of midwifery programmes.

Student experiences have also changed. Learning patterns, such as distance learning (Rustin, 1994), and resource-based learning, with an emphasis on student-directed learning, have resulted from a need to develop educational patterns that can accommodate increased numbers of students in higher education. Access to jobs and stability of continuous employment are no longer the norm (Rainnie and Kraithman, 1992). Thus, students can no longer be assured of obtaining a job at the completion of their programme.

This is the climate in which midwifery education finds itself and serves as a background for the context of this study. Midwifery is practice oriented, eclectic and draws from other academic disciplines. Midwifery education is dual centred, one centre within the contemporary health service, where the practice of midwifery takes place, and the other within an higher educational environment where the student receives the formal educational thrust of her programme. Changes within both these public services affect the way in which professionals and students respond to each other and the formation of educational relationships.

The structure of midwifery education involves a tripartite relationship between the teacher, the practitioner midwife and the student. The triangular relationship, described by Barnett, Becher and Cork (1987) between academics (teachers), the practitioners (midwives in clinical practice) and the students is the focus for this study. In analysing these relationships, the practice of midwifery, the nature of midwifery as a profession, its knowledge and learning relationships for its education are critically reviewed. The relationships between the three groups of actors, the teachers, the practitioners and the students are specifically explored. An exploration of educational relationships cannot be divorced from the clients who are central to the professional purpose. The woman and child, in midwifery, have a different set of relationships with practitioners and students in student learning. This forms a parallel set of relationships for students in their education. The exploration in this study is the set of relationships between the teacher, practitioner and the student that recognises that the focus of the profession is the clients whom it serves. Central, therefore, within the triangle of educational relationships is the mother and family. The study does not seek to explore the dimensions of clinical competence or capability, or identify the specific role of each of the actors. Neither does it specifically identify the impact of relationships that are made between mother and child and the student, apart from those associated with the relationships between professionals and students. It sets out to identify the nature of relationships in learning during the period of the 1990s.

The study offers an analysis of relationships in contemporary practice through an empirical study of the three groups of actors; academics and clinicians, who have a key role in education of students, and students. All are the essential players in

midwifery education. The academic and the practitioner are, within this text, together referred to as educators. The investigative part of the study was undertaken in midwifery educational establishments in the United Kingdom. A theoretical schema for a framework of relationships in professional preparation for midwives is offered through the use of a grounded theoretical approach.

The thesis emerging from this study is that relationships between professionals and students affect a student's ability to learn. The study demonstrates that teachers and practitioners have complementary roles in assisting student learning. The context and setting in which relationships occur and the perceptions and expectations of each individual within interactions can enhance or inhibit relationships. Four propositions are presented. Firstly a divergence of beliefs and values for midwifery, its theory and practice, held by both academic and practitioner, can cause conflict for the student.

Secondly, a gap between theory espoused by the teacher and practice experienced by the students is widened when there is no contact or relationship between these two members of the triad. Therefore structures in place that promote contacts between academics and practitioners are important. Thirdly, the organisational processes that influence the environment, enabling contacts between teachers and practitioners can also promote relationships. Fourthly, relationships between professionals and students depend upon a complementarity of interpretations of each other's understandings. This will be enhanced by dialogue between each of the three groups.

## **The background to the study**

### **A changing society of health care**

Chapter two traces the historical changes of midwifery relevant to its education. The political and social influences on the structure of society, its health and educational services have altered methods of delivery of care and education of midwives. The effects upon midwifery education are changes within the health service that require professionals to adapt and respond to individual clients in diverse social contexts.

The reforms of the 1980s and the 1990s (Department of Health, 1992a; Great Britain, 1992a; Department of Health, 1993; Great Britain, 1997a) have influenced the ideals of professionals and the expectations of clients for the delivery of maternity care. The Health Service reforms of the late 1990s impact upon the way in which midwifery care is delivered. There is a shift of emphasis to community oriented care; the rights of the individual to make her own choices for her care; and for midwives to work with women in partnership (Department of Health, 1998b; Great Britain [Winterton Report], 1992; Department of Health, 1993).

The management of midwifery services has undergone frequent changes since the Griffiths recommendations (Department of Health and Social Security [Griffiths Report], 1984) in the 1980s. Midwifery services are organised within business management units or directorates. An emphasis on cost effectiveness and efficiency has resulted in an examination of the role of the midwife (Department of

Health, 1998b), and the skill mix of staff delivering care within the service (Department of Health, 1999a). There is an emphasis on the accountability (UKCC, 1996) and autonomy of the professional (Department of Health, 1998b), while at the same time a requirement to conform to the policies and practices of the organisation. These influences provide the context for the environment within which students learn. Midwifery education attempts to endow students with the necessary knowledge and skills to adapt to the altering roles and responsibilities of professionals within the health service, rather than anticipate a continuation of a traditional role.

### **The changing nature of education**

The incorporation of midwifery education with nurse education in higher education has brought changes, not only in managerial structures and larger group sizes, but also in curriculum delivery, such as modularisation of educational programmes, and learning through media, by distance or by resource-based materials. The academic nature of higher education, with its valuing of scholarly activity, has a less overt emphasis on the vocational and clinical nature of education.

Higher education is not without its own changes, with a drive towards more occupationally led courses. This has been to meet the demands of employers and industry (Usher, Bryant and Johnston, 1997) with a new diversity in applied

knowledge forms rather than traditional disciplines, though this creates a climate of uncertainty of direction (Great Britain [Dearing Report], 1997b).

The new diversity offers midwifery opportunities within higher education. Midwifery education draws upon disciplines of sciences and social sciences and uses the knowledge of these disciplines to develop its own knowledge for practice. The relationships between clinical practice and education are pivotal, not only to advance the profession's knowledge but to assist students to recognise their role in learning to adapt to a world of diversity and change.

### **Midwifery and its education**

Midwives care for women and their babies during a life event that has an impact on the future of families. The nature of midwifery is emotionally and physically demanding, sometimes requiring skills of an intimate nature (Flint, 1986). It is a professional practice that is gendered both by women as clients and, in the main, its professionals. It is a profession, which is female oriented and a practice which can be subject to the feelings of both the professionals and clients. In situations of stress or emotions, personal relationships, which are a sharing of private details, can cross professional boundaries. Learning intimate skills requires professional educators to be sensitive to the student's personal circumstances as learning midwifery cannot be divorced from the subjectivity of a student's own life. Learning to be a midwife is learning to be powerful. Midwives in their role

influence women and have the ability to empower women and to assist them to take control of their own lives (Allen, Bourke Dowling and Williams, 1997).

In the past, the expectations and requirements of the health service have dominated the culture for professional preparation of midwives, and the midwifery student has been socialised by those already working within the health service. The role and preparation of the midwife has been likened to that of the nurse who is educated and trained to care for the sick (Witz, 1992) but the event of childbirth is a normal healthy occurrence within a family. Therefore, professional knowledge and expertise differs from nursing in that the focus is to promote expectations of health and well being, rather than a role of caring.

Within the midwifery service, there has been a strong bond between educators and service managers in the development of both the student and the clinical service. Prior to the nursing and midwifery management re-organisation in 1973 (Ministry of Health [Salmon Report], 1966), many teachers in midwifery had a clinical responsibility, and shared duties with midwifery managers. Formal midwifery education emerged in midwifery schools, which were small entities within and of maternity units, but since the 1970s there has been a progressive closure of small midwifery schools and units. At that time, many schools were situated with classrooms and offices within the clinical service area. This close proximity between midwifery teachers and clinical practitioners enabled both to influence each other and to engage in joint decision making. It also assisted the teachers in their being kept informed of contemporary practice.

A further aspect affecting the professional preparation of the midwife was the structural changes in nurse and midwifery education. Mergers and amalgamations of small schools into larger colleges of nursing and midwifery in the 1990s brought this about. Although midwifery and nursing are separate professions in legislation (Great Britain, 1979), there is a movement towards a shared control and organisation of education. Amalgamations of collectives of schools of midwifery and nursing into one establishment have resulted in joint policies and procedures for the larger numbers.

### **Professional preparation of the midwife**

Midwifery, like nursing, has not aspired to become a fully-fledged profession having full autonomy, though it can be considered a semi-profession (Etzioni, 1969). Etzioni describes a semi-profession as one with less status than professions such as lawyers, or doctors, as there is a shorter duration of training, a less specialised knowledge and less autonomy but there is more societal control. The midwifery profession has a philosophy of a traditional culture with strong links between education and clinical staff. The evolution of relationships in education relate to its past history and background.



## **Patterns of midwifery programmes**

Until the late 1980s, midwifery training in the United Kingdom was mainly an eighteen-month programme offered to those who had completed three years training for nurse registration. This pattern has altered with a three-year non-nurse programme introduced for students who have the ability to undertake a diploma or degree course. Non-nurse student entry is from all walks of life. These students have not been socialised by the culture of working within the health service. They more easily develop a questioning approach to their work (Radford and Thompson, 1988) whereas students, who have spent a minimum of three years within the health service, have already been inducted into the norms of the nursing culture. Differences in previous experiences affect relationships that students build with professionals.

The decision to incorporate all midwifery courses at diploma level and above within higher education from 1994 (English National Board, 1991) has involved different, but nonetheless subtle changes, of ways in which the curriculum is delivered. Though the education requirements have been retained, alterations in class sizes, travelling to clinical sites, an emphasis on teaching disciplined-based knowledge, and self-learning have required curricula changes.

Different values are placed upon the academic and vocational content of the midwifery course by the education institutions and the health service institutions. The vocational component of midwifery lies in the use of skills in practice that utilise appropriate knowledge. Academic institutions emphasise systematic

formal, identified knowledge especially that drawn from the science-based disciplines. Midwifery draws upon such discipline-based knowledge and uses this in its practice. The teacher has a fund of academic knowledge and seeks to make sense of this to the student.

Midwifery is a vocationally oriented profession. Midwives develop their knowledge and skills through their experiences in practice as well as through formal knowledge. The nature of practice uses a variety of disciplined-based knowledges. Finding a balance between the strands of both academic disciplines and vocational components is important in curricula planning. Values placed upon theoretical learning and learning in practice by both academic and practical cultures influence students' perceptions of the importance of each.

Students develop their understandings of theory from both the academic institute and clinical practice. Learning theory is acquiring an understanding of a perceived truth or explanation of phenomena in practice. The teacher may offer new knowledge or give guidance to sources of knowledge to explain phenomena but the clinician influences the student's interpretation of theories within practice. A student's experience of clinical practice alongside an experienced practitioner forms an important part of the process of learning. Students also derive their own theories from making sense of experiences in both places. They evolve their own theories from their understandings to use in practical situations.

## **Midwifery as a profession**

Midwifery demonstrates not only the characteristics of a caring profession (Etzioni, 1969) but its professional preparation gives the student, on qualification, the ability to practise autonomously (Friedson, 1972). The study considers characteristics of a professional that are acquired by students.

Of particular significance, in learning to be a professional, is assimilating the code of ethics of professional conduct (Goodlad, 1984; Millerson, 1964; Goode, 1969). The espoused code of ethics is learnt as part of the propositional knowledge of the profession. Such knowledge of ethical behaviour is interpreted through social experiences within and outwith professional practice. Of particular relevance, implicit in professional codes of ethics, are relationships with clients and relationships between professionals themselves.

Professional characteristics of midwifery, in particular its control, its propositional knowledge (Eraut, 1994) and its concepts are acquired by the student through the ambience of clinical relationships. Professional skills, such as those of an intuitive nature and problem solving, problem judgement, and solution implementation are learned in the practice arena (Benner, 1984). Benner also describes abilities such as coping with high threat situations, stability under pressure and compassion, all of which are relevant to learning midwifery. Autonomy in professional practice (Kaplan Daniels, 1973) is acquired through recognising the boundaries of the professional. Kogan (1986) and Adelman and Alexander (1982) emphasise the importance of this characteristic in relation to professional decision-making that is

acquired in learning practice. Acquisition of this professional knowledge by the student occurs within the ambit of the practitioner /student relationship.

Midwifery is a profession where the lay public has a strong representation and legitimate voice. This reflects the extent to which women are central to the service. There can be a dichotomy between women who request their rights to make choices for their care and a provider who conducts the service. Midwives enter into partnerships with women where both become negotiators and decision-makers. This feature contrasts with a professional ideology where a profession guards the knowledge. Midwifery typifies semi-professions in contemporary society where the public may share in acquiring the detailed knowledge of the professional (Usher, Bryant, and Johnston, 1997). Lay representatives and midwives co-operate to develop agreed standards of maternity care.

Part of midwifery knowledge is public knowledge. This, in maternity care creates partnerships between women and midwives. However, this sharing of knowledge may diverge from the role idealised by medicine that has a controlling influence over client information within health care. These contrasts in professional culture expose midwives to conflicts within themselves, as professionals, and with their co-workers. This is because they are bridging two cultures, one of professionals in health care and the other of public partnership. The conflicts are in particular, emphasised in meeting individual women's choices flexibly that can differ from ideologies presented with within policies of organisations. Learning the capacity to manage these situations is developed through working relationships between students and practitioner.

## **Nature of midwifery knowledge**

Since the turn of the century and the introduction of formal education for midwives much of the knowledge of midwifery was founded upon medical sciences. Knowledge was based on paradigms of scientific enquiry, whereas other types of midwifery knowledge emanate from custom and practice. These latter forms of knowledge relate to vocational knowledge and social forms of enquiry. A growing field of knowledge relating to midwifery is still developing. There is a view that academic and scientific knowledge is a pure intellectual and rational form of enquiry (Maxwell, 1984) but there are different paradigms within which scientists present knowledge (Phillips, 1987). Examining the nature of knowledge is to explore how relationships affect the students' acquisition of knowledge. Eraut's (1994) map of knowledge, of propositional, personal and process knowledge, will be drawn upon later to analyse midwifery. A further area, midwifery interpersonal knowledge, of an ethical nature, is also developed here as a part of midwifery knowledge.

There is a dichotomy between values placed upon a) the scientific content of education on the one hand and b) the more interpretive aspects of midwifery on the other. Scientific knowledge, essential for the profession and its acquisition, is dependent upon the cognitive skills of the student, assessed through a scientific approach, that is, through setting objective measures that can be tested. The place of interpretive knowledge with its associated intuitive, interpersonal and communication skills, all of which are essential, are not so well defined (Atkinson

and Claxton, 2000). It is these latter elements which, by their nature, are difficult to assess and test. This enquiry explores relationships, that affect the acquisition of skills in practice, such as, decision making, problem solving, evaluating practice, and remaining calm under stress. These concepts are combined with scientific knowledge. Thus, midwifery and its practice is a balance of a complex interweaving of all forms of knowledge.

### **The effects of the curriculum**

The curriculum, both overt and covert, influences the student in discerning the concepts of midwifery. The covert curriculum has a strong influence upon the student who spends 50-60% of her time in the clinical practice (English National Board, 1994b). It is not only the cognitive and clinical components of a curriculum that affect the relationships between professionals and the students; it is how relationships are demonstrated in a curriculum framework to promote interpersonal development and the covert influences in clinical practice.

The overt curriculum may spell out approaches to learning by adult students, such as negotiated and contract learning. Approaches to and interpretation of the curriculum are dependent, however, on a dynamic interaction between professionals and students. Adult styles of learning and educational approaches are appropriate for student midwives, who may differ individually in their learning styles (Marton, Hounsell and Entwistle, 1984; Gilbert, Burrows and Pollert, 1992).

Therefore students' educators require skills to facilitate the different learning processes.

Induction to a profession is achieved partly through educational relationships (Olesen and Whittaker, 1970). Teachers influence the student in learning according to their own beliefs (Phillips, 1987). Differing opinions and beliefs held by teachers and practitioners of midwifery offer contrasting perspectives from which students may draw their own epistemological basis. Notwithstanding this, students develop their own theories from a) acquiring theoretical knowledge in the academic institution; b) learning from practitioners in practice, both through discussion and observation of practice, and c) using reflection to develop personal theories from their own experiences.

### **Educational and clinical learning environments**

The purpose of effective learning is to develop capability in practice, (Barnett, 1994; Eraut, 1994) which is a forerunner of competence (Eraut, 1994). Students can become capable at the end of their education programme, though not necessarily competent to practice independently (Benner, 1984). Relationships between teachers, practitioners and students can bridge their understandings of both theories and practice through dialogue between each of these players.

Different forms of relationships are appropriate for the student to acquire varied knowledge forms and skills for competence in practice.

Practice and experience are not straightforward sites of learning. The educational and clinical environment in which learning takes place, also influences a student's experience of life and practice. Each situation provides a particular context, requiring interpretation, that is a pre-requisite to learning experientially (Usher, Bryant, and Johnston, 1997). The ambience of the environment affects the students' ability to learn (Spouse, 1990; Fretwell, 1985).

Ogier (1989) cites a study by Bryant (1985) who showed that, though practitioners often sought a partnership with teachers, this relationship was often lacking. This reduced the level of communication required adequately to assist the student to connect theory to practice. Communication between teachers, practitioners and students is restricted where there is limited contact. The consequence of these influences upon relationships of the teachers, practitioners and students is associated with the concept of trust. The presence of stress in learning is ameliorated when trust relationships emerge (Quinn, 1988).

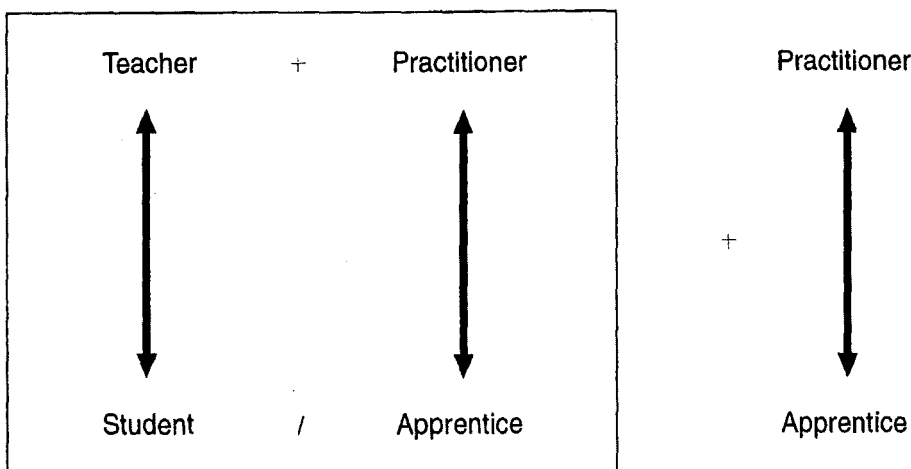
The environment of learning is determined by the culture of the organisation. The culture influences the building of relationships between teachers, practitioners and students. An organisational culture that promotes dialogue between teachers and practitioners will enable sharing of beliefs.



## Teacher, practitioner and student relationships

Barnett, Becher, and Cork (1987) presented a theoretical model for professional preparation. Their study of relationships between academics, practitioners and students, in nursing, pharmacy and teaching, provide a map of educational processes. In their analysis (figure 1.) they indicate a preference for a model of partnership and collaboration found in their examination of the preparation of student teachers.

**Figure 1: Model for the preparation of students in teacher education**



(Barnett, Becher, and Cork, 1987)

In this model, lecturers and practitioners work together (shown within the box) to develop student competence. The lecturers are concerned with teaching theory and assisting students to reflect on practice. There is a communication link between

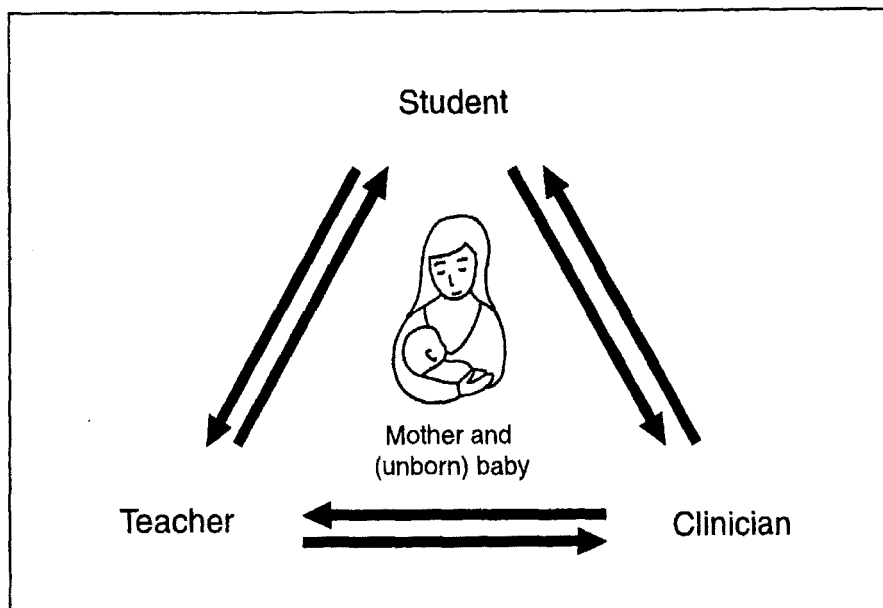
the teacher and the practitioner about the student's overall progress on the programme ( + within the box). Thus, there is a partnership between the practitioner and the teacher who work in parallel with each other. The student has a role either as student or apprentice. Students stand in a student relationship with teachers but are apprenticed to practitioners who have responsibility to assist students in their development of professional skills (shown by arrows and + outside the box).

There is a complementarity in the two professional roles of the teacher and practitioner in promoting student learning (Barnett, Becher, and Cork, 1987). This complementarity of function may not be recognised by all the players in the triad, of teacher, practitioner and student. The complementarity resides in the situation between the teachers and practitioners working in a parallel partnership towards mutual goals for student learning. The student moves from the role of a student in the academy to that of apprentice in practice. These roles have a distinctive but complementary function. Similarly the roles of teacher and practitioner have a complementary function and are in parallel with each other in promoting student learning.

This model, a partnership model, between teachers and practitioners is appropriate for midwifery as it offers the following: a partnership between teachers and practitioners for student learning and co-operation between service and education for professional learning. Complementarity between teacher and practitioner, with each developing their own distinctive role in relation to student education, gives recognition of each other as equals in the education process. What these authors

do not make explicit is the role of the student, who contributes to the collaboration and is also a participative partner in her own learning process. The model presented by these authors is described as a triangular model but their diagram reflects a parallel partnership model. What is missing from their model is the student's responsibility for her own education. Including the student with an equal responsibility for her education will alter the parallel partnership, described above, to a triangular relationship model. The model of midwifery education is discussed here as a triangular relationship where three actors; (the teacher, the practitioner and student) each have a role in the learning process (figure 2.).

**Figure 2: The triangular relationship in midwifery education**



Central to the triangular relationship in midwifery is the mother and baby. Therefore, this study considers the components that form a working educational

relationship between each of the three actors with consideration of the client in this relationship.

### **The roles within the triangular relationships**

The clinical midwife, (also referred to as the practitioner), works alongside the student during clinical practice. The academic, (as lecturer or teacher) in midwifery is the second professional involved in student education.

Teachers and practitioners, having differing roles, provide different perspectives in the educational process. The varied beliefs and values of teachers and practitioners can widen a student's knowledge and experience. Complementary stances can result in replication, which help a student's understandings. Understanding is unique to the individual (Barnett, 1994). Through her understandings a student is able to develop her own sense of validity of her practice (Barnett, 1990). When there is little commonality held of ideals for practice by teachers and practitioners, divergent views could cause conflict and confusion, which may interfere with learning. Alternatively, a student's understanding can emerge from diversity of opinions and reasons by evolving a personal meaning (Barnett, 1990) or a meaning may emanate from debates between teachers, practitioners and students.

This is where a dialogical relationship can promote learning. A dialogical relationship is one where there is debate. In learning, it is one where both parties enter into a process of argument to clarify and understand meanings of situations.

Within a relationship it is a partnership of exploration with critique to clarify understandings. It can occur where there is an environment that promotes enquiry.

The level of accountability and responsibility held by the teacher to the student may differ from the level of accountability that the practitioner holds to the student. The teacher is responsible for the student and her progress whereas the practitioner is primarily accountable for the clients. Differences in accountability may influence teachers' and practitioners' responses and attitudes to the student. The above issues underlie the importance of discovering the nature of relationships that promote learning.

### **Educational relationships in practice**

Chapter 2 provides the background to this study. Section 2, analyses three dimensions of midwifery, which relate to the building of educational relationships: chapter 3 analyses midwifery as a profession with comparison to traditional views of a profession and explores professional concepts that influence the relationships, which students form in learning; chapter 4 analyses the nature of midwifery knowledge and chapter 5, using an analysis of curriculum documents, examines curriculum issues, which relate to students' learning. Section 3, chapter 6, explains the methods of enquiry used in this study. In Section 4, the analysis of the empirical study offers three perspectives on relationships. Chapter 7 presents the contexts within which relationships occur; chapter 8 suggests components that build a framework for relationship formation and chapter 9 presents influences upon relationships in practice.

Data from the interviews indicate that relationships can aid a student's capacity to integrate theories in practice. An essential feature of learning how to practise is through interaction and observation of the experienced practitioner. An active dialogue can stimulate a student's ability to interpret knowledge into practice. The student learns to reproduce the practices of midwifery (Chapter 10). Through experiences, reflection with critical thinking and repetition of skills and decisions, the student develops her own knowledge repertoire. The idea is advanced that these processes are encouraged through relationships. The student's reliability and safety as a practitioner are reliant on processes of integrating her own knowledge, experience and observations into her practice. Schon's (1991b) description of reflection-in-action is relevant here. Relationships can be catalytic in processes of reflection. The caveat is that they can also negate the process.

Relationships between two or more people are also dependent upon encounters and interactions between each of the actors. There is a tension between social and professional relationships and the role of friendship relationships in midwifery. Symbolic interactionism is each person's interpretation of the meaning of an interaction and aids a mutual understanding between the two parties to form relationships (Blumer, 1969). However, there are occasions when there are no interactions between students and their mentor or teacher. This may result in the student being static in learning.

Section 5, (chapters 10 and 11), provides an analysis of and a framework for educational relationships. It draws together the themes from both the literature explored and the empirical study, and links these with social, psychological and

educational theories of relationships. The proposal made is that where relationships alter the affective domain, and self-esteem is reduced, learning is inhibited. In contrast a relationship that promotes interaction stimulates a praxis of learning. Praxis is concerned with thoughts and actions in practice. It is an ethical process in which there is a self-reflective process that results in formulation of new knowledge and actions in situations of practice (Carr and Kemmis, 1993). A framework for building relationships in learning is suggested that emerges from two processes one, complementation (a unity of meanings between actors) and two, complementarity (a matching of understandings). Both processes require a forum resulting from encounters. The conclusion, chapter 12, presents a theoretical basis for a model for professional preparation of midwives in the future.

## **Conclusion**

Both the formal and informal educational processes underpin the relationships between teacher, practitioner and student, through which knowledge and professionalism are developed. All three groups can learn and be educated by the other. Within the triangular relationship of the academic, the practitioner and the student, the different beliefs and values held between education and health institutions may result in a divergence between theoretical understandings and practice. Furthermore, the teacher and practitioner may also have different perceptions of their role and accountabilities to the student. The dynamic of relationships between these people may alter the influences and the extent to which a student develops her knowledge and skills to achieve professional competence.

relationships between these people may alter the influences and the extent to which a student develops her knowledge and skills to achieve professional competence.

The structures of the organisations of the health service and higher education offer different environments for student learning. Though they are undergoing changes, they both offer different perspectives as part of a student education. They have a complementary function in preparing student midwives for practice, though their environments can be a complex terrain. Relationships that promote learning by students can assist to overcome some of the complexities.

The preparation of the midwife in the future will require her to respond to the changes in the health service. Therefore education and training will need to respond to demands of the workplace. Relationships in education can be influential in the development of the student; therefore an adapted model of Barnett, Becher and Cork (1987) is presented as basis for discussion in this thesis to explore and illuminate relationships that promote and negate learning by students in a practice oriented profession. It also investigates the components that build relationships and explores the contexts within which relationships form.



## **2. From apprenticeship to studentship: models of midwifery education**

### **Introduction**

This chapter has two purposes: firstly to trace the training of midwives, from early in the last century within an apprenticeship, to studentship in higher education at the end of the century; secondly to identify possible models of contemporary midwifery education within the studentship paradigm.

Traditionally, the skills of midwifery were passed on from woman to woman. Women learnt alongside those considered to be wise and mature practitioners of the profession (Donnison, 1988; Towler and Brammell, 1986). In the seventeenth century, midwives were important to women, not only for their role in childbirth but also as healers (Wilson, 1995). The midwife, as an important person in the lives of women, was often viewed as a friend who interceded on behalf of women (Heagerty, 1996).

The beginning of the twentieth century saw the emergence of some of the hallmarks of a profession, such as the establishment of a professional organisation, standardised training with examinations, and the establishment of a regulating body. It was not until 1979 with the Nurses, Midwives and Health Visitors Act that midwives were majority members on the policy making forums within their statutory body. It was only from this time that midwives were able to take responsibility for the emergence of their own profession.

Midwifery education is briefly examined here from an historical perspective. The subsequent discussion examines the evolution of midwifery education from its location within the health system to its position within higher education. A tentative explanation is then developed of the effect of these shifts on models of learning relationships. The chapter aims to set the scene for the analysis of the study and its methodology.

### **Emergence of formal midwifery education**

An awakening of interest in the sciences of health in the sixteenth and seventeenth centuries in England and on the European continent was associated with the emergence of a science of midwifery (Towler and Brammell, 1986; Donnison, 1988). During the nineteenth century, midwives received formal instruction in the lying-in-hospitals, a name given to hospitals where women went specifically to give birth (Rhodes, 1977). Though early records show that some midwives received some formalised training in central London from the seventeenth century (Adams, 1989), most midwives did not have formal instruction until the latter part of the nineteenth century (Towler and Brammell, 1986).

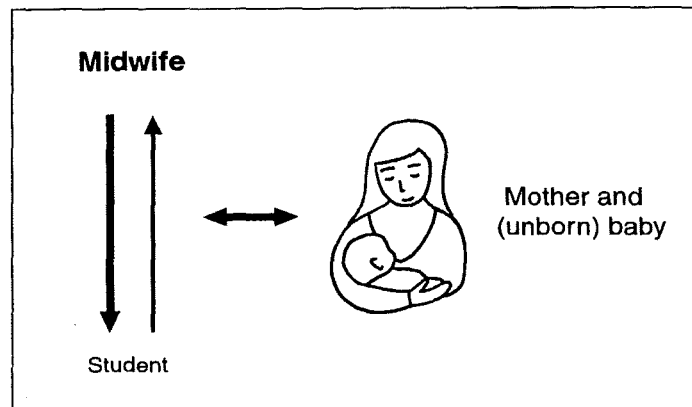
The first Midwives Act, passed in 1902, set up the statutory body of the Central Midwives' Board as the regulating body for the practice and education of midwives. The primary purpose of this body was to protect the public and secondarily to 'secure the better training of midwives and regulate their practice' (Great Britain, 1902).

## **Traditional model of training midwives**

In a traditional apprenticeship, the trainee was dependent upon a single practitioner for instruction (Friend, 1992). The master, as professional and expert in practice, directs and gives instruction to the novice. Instruction depends upon the expert's generosity and beneficence. Freedom of the novice to practise is dependent upon the confidence of the professional and expert to let go, and the novice to be confident (Reid, 1986). The term apprentice implies a contract between a senior person and a novice for the latter to achieve skills to a certain level in order to become independent. This contract traditionally was likely to be one that was semi-formal, with an agreement between the expert and the novice, but which may not have been a written agreement, or with payment. This traditional way of learning midwifery, was a dual relationship between midwife and apprentice, in which the mother and baby, born and unborn, formed a third party.

When an apprenticeship is not formalised by an external authority that validates the training, the level of attainment will be dependent upon the expert imparting the skills. Thus, the quality of instruction is dependent upon the expertise and the sense of responsibility that the practitioner has for the trainee. The degree of freedom that the novice has to set up in independent practice depends upon the form of agreement held, the expert's view of the novice achieving competence and the novice's self-confidence to work independently (Reid, 1986). The novice repeatedly undertakes tasks or is involved in actions-of-practice, though this may or may not include any actions-of-learning. Some repetitive learning takes place. A diagrammatic model of the relationship is given in figure 3.

**Figure 3: The apprenticeship model**



In this model, there is a direct set of relationships between the professional, the student and the mother and baby. The mother with baby will require a certain standard of practice to be achieved. Features of an apprenticeship are given in table 1.

**Table 1: Midwifery education: features of an apprenticeship model**

- The focus is a set of practical skills;
- The apprentice works for a professional expert to achieve the required skills;
- The apprentice's labour is directed by the professional;
- The length of the apprenticeship is determined by the professional who determines the time needed to acquire the skill;
- The novice is dependent upon the professional for the standard and content of the experience;
- The novice learns skills by observing, and undertaking tasks repetitively to learn, which gradually becomes part of the novitiates' actions-in-practice;
- There is a direct set of relationships between the professional, student and the client for the practice to be fully realised.

adapted from Friend, P. (1992:423-430)

The traditional form of apprenticeship is still used today to train traditional birth attendants in parts of the world (Davis-Floyd and Sargent, 1997). Many midwives took up their practice as a vocation (Vincent Priya, 1992; Leap and Hunter, 1993). Through a system of apprenticeship women controlled the knowledge of childbirth,

with transference of knowledge from woman to woman. This method of a novice learning from a senior, has persisted into the twentieth century (Reid, 1986).

### **Formalised training and regulation**

The passing of the 1902 Midwives' Act was a watershed for midwifery (Great Britain, 1902). It represented the beginning of organised national training and education for midwives. The act itself was a form of controlling women who entered midwifery, as the members of the Central Midwives' Board were mainly obstetricians. The Board directed the form of training, oversaw examinations and controlled the award of the professional qualification (Witz, 1992). The Central Midwives' Board kept a roll of qualified midwives.

Formalisation of midwifery as a profession, through the Midwives Acts, began with an authoritative and controlling influence on practising midwives through inspectors of midwives, who subsequently became supervisors of midwives (Allison and Kirkham, 1996). The supervision of midwives was and is still, a formal structure framed within the legislation. Midwifery supervision continued to be a disciplining measure until the last decade of this century (Association of Radical Midwives, 1995). The statutory supervision of midwives is unique to the profession of midwifery, in that it is a legal requirement in place to protect the public and to promote good practice by preventing malpractice (Kirkham, 1996). It is a legal requirement in addition to the regulating body. The role of the supervisor of midwives is to promote safe practice and to reduce risks in childbirth, thus offering guidance and assistance to midwives on standards of practice. Supervisors of midwives have a specific training and are directly accountable through the statutory framework to the legislative bodies.

Midwifery supervision is a complex form of self-regulation of the profession. The complexity arises from a dichotomous role, one part as a mechanism to promote standards of practice, with an aim to support midwives in practice, and a second part as a policing and disciplining function for malpractice. Supervision of midwifery can lie outside the management function of the health service, as it is not explicit within job descriptions, and yet, through the legislation there must be at least one supervisor of midwives in all health districts.

The function was not always necessarily punitive since a supervisor of midwives can assist the midwife in her role and there has always had a strong element of promoting training and education of midwives (Kirkham, 1995; Kirkham, 1999). However, the effect of the statutory framework of supervision of midwives was to imbibe sense of authority in midwives and their trainees. Both were more likely to learn through strictures of rules and regulations in their relationships rather than to question judgements and action (Heagerty, 1996).

## **Pupillage**

Initially, from 1902, midwifery training was three months in length, and was lengthened to six months in 1916. Table 2. charts the changes to the length of midwifery training during this century. Nurses were permitted a two month remission from 1916. This link with nursing and the remission of training for registered nurses has resulted in midwifery evolving as a post registered qualification for nurses. From 1936 the training was split into two parts, the first part was eighteen months for non-nurses and six months for registered nurses. The second part was six months. A full training programme was two years for non-nurses and one year for nurses. The

education of midwives without a nursing qualification is increasing in this country today.

**Table 2: Changes in the length of midwifery training and relationships with apprenticeship, pupillage and studentship**

Year change made	Non-nurse entry for midwifery qualification	Registered nurse entry for dual qualification of registered nurse and midwifery	From apprenticeship and pupillage to studentship
Pre 1900	-	-	informal apprenticeship woman to woman
1902	3 months	-	introduction of formal midwifery training
1916	6 months	4 months	Pupillage in hospital      apprenticeship in community
1926	12 months	6 months	
1936	18 months + 6 months = 2 years	6 months - Part 1 6 months - Part 2 = 1 year	
1968-1976		Single Period (phased in) = 1 year	
1981	3 years *	18 months*	
1992	3 year diploma; 3 year degree; 4 year direct entry degree **	18 months accreditation at diploma as minimal level **	introduction of studentship in hospital and community

\* From 1989 diploma and degree programmes were validated (English National Board Report 1989-1990)

\*\* English National Board (1991)

Midwifery training took place in specialised maternity hospitals or within the midwifery departments of general hospitals. During the first part of training, trainees, as pupils, spent six or eighteen months in a maternity unit and received theoretical instruction. As pupils training in hospital they were not necessarily apprenticed to one midwife but gained experience by working alongside other pupils and other midwives

who supervised their practice. During their pupillage they were the lowest members in the hierarchy of the midwifery team. Pupils were usually taught by the superintendent of midwives, or her deputy who was the tutor. They also received lectures from the medical staff. Leap and Hunter (1993) report that trainee midwives, during their pupillage, had to learn long notes by rote with very little opportunity to discuss or reflect upon their learning.

Part 2, a six month period, was a requisite for trainees to become certified midwives. Not all nurse entrants progressed to part 2 of the course as the first part equipped nurses with a knowledge of childbirth to undertake work within the wider sphere of nursing. In part 2 of training trainees undertook an apprenticeship with midwives in the community for direct supervision and instruction. Some trainees lived in accommodation with their midwife for their period of instruction. They became involved with the social and domestic lives of women in the community (Allison, 1996), and it is likely that pupils were strictly controlled carrying out many domestic duties which were normal events in homes and hospitals in the 1930s, 1940s, and 1950s (Leap and Hunter, 1993). Even in the 1950s 'authority was deferred to inside as well as outside the home...' (Readers Digest, 1998). For much of the time, pupils carried out their work on their own but with reference to and under the authority of the midwife (Leap and Hunter, 1993). It is likely that the midwife gave detailed instructions so confirming her authority. Learning the practice of midwifery through apprenticeship with the community midwife may have been 'authoritarian' (Leap and Hunter, 1993) but pupils had the freedom to practise early in their training to develop their expertise, which gave them confidence to work when qualified (Allison, 1996).

By the 1980s only one institution offered a three year non-nurse entry training. Following a study by Radford and Thompson (1988) to assess feasibility of re-introducing a three-year programme there was a major shift to the non-nurse three year training in the 1990s (Fraser, 1999a). This led to an evaluation of the

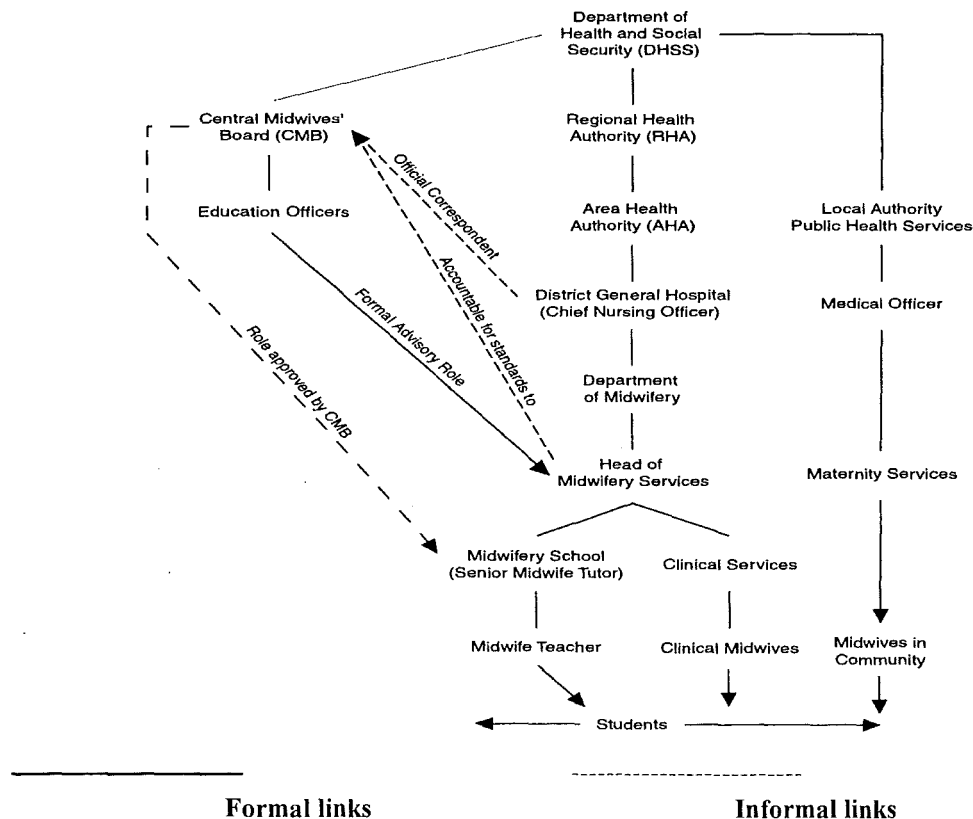


1998).

## The midwifery school within the National Health Service structure

The National Health Service Act (1946), which reorganised health care for the nation did not affect midwifery training institutions per se. The changes giving every pregnant woman the right to free medical care altered the pattern of delivery of the maternity services, resulting in an increase of maternity care being given in hospital. Midwifery schools, based in the hospital, were responsible for the training of students in the hospital and community but the tutor's influence was limited in the community. Figure 4 charts a representation of the relationships between the statutory bodies controlling midwifery education and its delivery in the 1960s and 1970s.

**Figure 4: Diagrammatic representation of the relationship between the statutory control of midwifery education and its delivery in the 1960s and 1970s in England**



Midwives in the community were responsible to the Local Authority health services and had a tenuous link with the training school, though they took responsibility for the supervision and instruction of pupils during their community practice. The pupil midwives, whilst in the community, received an experience that could vary considerably and which would depend upon the relationship between the midwife and pupil.

### **From home to hospital**

A revolution in the maternity services began in the 1950s and over the next two decades. Technological changes in care and an increase in medical and technical care brought this about. Changes to the syllabus of training programmes were introduced by the Central Midwives Board in response to the social and technological changes occurring in society and in health (Central Midwives Board, 1960; Central Midwives Board Annual Reports, 1959 - 1981; Central Midwives Board, 1963a; Central Midwives Board, 1963b; Central Midwives Board, 1971).

By the mid 1960s, the home confinement rate dropped and hospital beds were becoming overcrowded. This changing pattern altered the clinical experience available for pupil midwives. This change was further exacerbated by reports including the Ministry of Health [Cranbrook Report], 1959 and the Ministry of Health [Peel Report], 1970. This latter report recommended a 100 % hospital delivery rate, stating that the hospital was the only safe place for confinement. The reduction in home births over the 1960s resulted in pupil midwives undertaking more of part 2 of training in hospital so as to obtain the requisite experience for practice. Less time accordingly was spent in personal apprenticeship to a midwife working in the community. By 1975, the home confinement rate had dropped to 3% (Tew, 1995), the

effect of which was to reduce both the one-to-one relationship with midwives and pupils' ability to gain confidence in home births and in community midwifery.

As new knowledge increased it was included in the syllabus with subjects such as the psychological aspects of pregnancy, genetics, embryology, neonatal paediatrics, and family planning (Towler and Brammell, 1986). There was a gradual increase in the theoretical content of the programmes. Tutors found it increasingly difficult to deliver the expanding formal knowledge and needed to find new forms of curriculum. There was a shift from tutor based practical assessments to using practitioners to assess pupil midwives (South East Thames Regional Health Authority, 1987).

The nursing services' structural reforms in the 1970s (Ministry of Health [Salmon Report], 1966) produced a hierarchical structure in principal, senior and nursing officers (midwifery). The effect on midwifery schools was to produce a parallel hierarchy with a senior teacher and teachers accountable to a principal midwife within the institution. A change of name from 'tutor' who instructed pupils to a 'teacher' who educated students was not explicit but the form and role of the educationalist gradually transferred the role of teacher to that of an educator (Bent, Kilty and Potter, 1976a). This re-organisation paved the way for teaching staff to review new forms of education and prompted curriculum innovation including new forms of assessment and new teaching methods (University of Surrey and the Royal College of Midwives, 1977; Allis, 1978; Maclean, 1983a, 1983b).

Following the expansion of the Health Service building programmes in the 1960s and 1970s, and the National Health Service reorganisation of 1974, district general hospitals were established (Department of Health and Social Security, 1972). District general hospitals' maternity units became the centres for education and practice. The reorganisation of the Local Authority Social Services and Welfare departments resulted in the local authority midwifery services being integrated within the hospital

midwifery services. This brought the total control of midwifery education under the heads of midwifery services within district general hospitals' midwifery schools by the late 1970s (Department of Health and Social Security [Mayston Report], 1970; Department of Health and Social Security [Seebhom Report], 1970).

### **Training in the National Health Service**

The heads of midwifery services retained overall control of the midwifery schools. They were accountable to the Central Midwives' Board for standards of clinical care, the practice of midwives and the education and training for the community and hospital service. The control of midwifery education was invested in educational officers appointed to the Central Midwives' Board, to inspect and give advice to the midwifery schools on practice and education (figure 4.). All midwifery schools throughout England and Wales were inspected.

Many schools were physically situated within the maternity unit premises, which fostered a close relationship between tutors, clinicians and pupils. Tutors were involved in the day-to-day management, decisions in clinical care and for the policy making of the maternity unit. They instructed, were seen on a daily basis and worked alongside pupils in their clinical role, thus being an exemplar. Tutors acted as role models for clinical practitioners and could be called upon to give advice or direction when difficulties occurred. Allison speaks of their 'clinical expertise being without challenge' (Allison, 1996). Tutors were immediately conversant with events in practice. The flow of information was direct.

Theoretical instruction and practical training could be integrated, but in many instances formal knowledge was not always related to practice, teaching was didactic, the syllabus restrictive, and pupils were required to do what they were told rather than

think for themselves. Training and being trained invoked a sense of commitment to women and their babies. Much depended upon two levels of relationship, one between the pupils, the teachers and the clinicians, and the second between the teachers and the managers who controlled the maternity units. These managers held the key to changes within the midwifery school. Their view was that midwifery training was to provide a commitment to maternity care.

### **Professional education and control**

Dissatisfaction with nurse education led to the setting up of the Committee on Nursing (Department of Health and Social Security [Briggs Report], 1972), which proposed one statutory organisation for nursing and midwifery to replace the existing separate statutory bodies. The main recommendations of the Briggs Report were implemented in the 1979 Nurses, Midwives and Health Visitors Act, providing one statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, (UKCC), as the central policy making body for the professions. This paved the way towards self-regulation of the profession. The education and training functions were invested in four National Boards, one for each country in the United Kingdom. Appendix 1 traces key events in this century that have had an impact upon midwifery education, and the changes in relationships from an apprenticeship to a studentship in a move to professionalisation.

With the emergence of technology, in-service and continuing education became an increasing feature in midwifery education. The role and responsibilities of the midwife developed to take on new clinical skills in areas such as fetal



cardiotocographic monitoring, interventionist drugs, suturing and ultrasound. The technicalization of birth emerged with the woman being part of and compliant in the process (Wagner, 1994). The midwife participated in this process, so allowing her competence in non-interventionist birth to diminish. The responsibility for educating and training midwives with new skills was shared between clinical managers and midwife teachers. The horizons of the midwife were to widen to encompass new skills and knowledge in areas such as counselling, research, and health promotion with an emphasis on professional development (Bent, Kilty and Potter, 1976b).

Professional developmental programmes for midwives responded to the changes taking place within the profession with a wide subject range such as accountability; bereavement/loss; assertiveness; ultrasound; health education and pharmacology. Teachers developed curricula to educate students. Practitioners assessed students in clinical practice (Central Midwives Board, 1979; English National Board, 1985; English National Board, 1991). Midwives were requiring new knowledge which included developing their teaching skills. The importance of practitioners' roles and relationships with students in learning and their responsibilities in practice-based assessment were becoming evident.

### **From training to education**

Before its demise, in 1979, the Central Midwives' Board specified criteria for the theoretical content of the programme, the clinical experience to be provided and the ratios of clinical staff in the hospital, the community, and for teaching staff (Central Midwives' Board, 1979). Practitioner/student ratios were set for both hospital and the

community indicating the relevance of the role of the practitioner (Central Midwives' Board, 1979). A minimum intake size was limited to eight students, as a cohort below this level was not considered viable for group participation. If the student number was above ten there was to be an increase in the ratio of teachers (Central Midwives' Board, 1979). These prescriptive levels for classroom interaction were considered necessary for discussions of the more intimate subjects of midwifery.

An eighteen month programme for nurses, as the main route to educate midwives at this time, resulted from negotiations for the educational programme to meet the requirements of the E.E.C. Midwifery Directives (European Economic Community, 1983). The new programme provided a framework for movement from apprenticeship and pupillage to studentship. In 1985 the English National Board produced a document for approval of course submissions (English National Board, 1985). Subsequent course submissions were required to demonstrate a course philosophy with a curriculum framework and strategies to support students in education and practice and for auditing the educational environment.

There was a shift of control from the medical staff regulating entry to the profession. Consultant obstetricians were no longer invited to examine students at the qualifying examination. Midwifery schools were able to develop curricula to meet the needs of students in different parts of the country, reflecting midwifery care offered. This was a movement towards self-regulation.

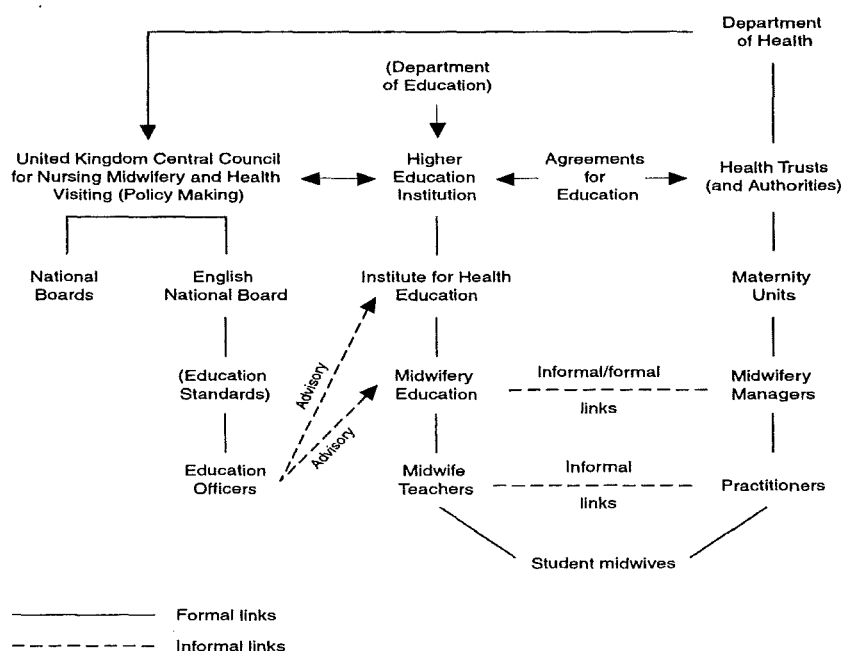
Students were encouraged to be representatives on course management teams and all courses were required to be evaluated. This gave students a formal voice, though the

process of course evaluation and involvement of students had previously been a feature in the curriculum of midwifery schools. The ground for moving from pupillage to studentship, tutors to teachers as educators and clinicians to practitioners as educators was now prepared.

### Towards self-regulation

During the mid 1980's the Regional Health Authorities in England prepared strategies for the future of nursing and midwifery education, (South East Thames Regional Health Authority, 1987), North East Thames R.H.A.1987, and North West Thames R.H.A. 1988). From 1987 to 1990, mergers and amalgamations took place of schools of nursing with midwifery in England. This resulted in heads of midwifery education changing their responsibility in line management to principals of colleges/ institutes of nursing and midwifery (figure 5.).

**Figure 5: A diagrammatic representation of the lines between the statutory bodies, higher education and the health service for education of student midwives (1998)**





In 1988 the English National Board issued guidelines to colleges/institutes of nursing and midwifery, to assist the arrangements for formalising links with higher and further education (English National Board, 1988). By 1992 many colleges of nursing and midwifery had merged with higher education (English National Board, 1994a). Midwifery schools moved their physical location to higher education campuses.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), provided the professions with guidance papers on codes of behaviour and ethical standards (UKCC, 1983, 1984, 1992; UKCC, 1987; UKCC, 1989b; UKCC, 1992a, 1992b). These are periodically updated (UKCC, 1996; UKCC, 1998a). In its role the UKCC set structures for self-regulation of the professions, ensuring standards to meet the public interest.

**Table 3: Progression towards diploma and degree programmes in midwifery in England**

Date	Number of education centres with award approved
1989	First diploma of midwifery approved in higher education*
1991-1992	3 programmes at degree level 19 programmes at diploma level  Programmes validated 22**
1992-1993	6 programmes at degree level 25 programmes at diploma level  Programmes validated 31*** bringing total programmes to 49****
1993-1994	80% of all programmes at either degree and diploma level*****

Figures taken from English National Board for Nursing, Midwifery and Health Visiting ( ENB) Annuals Reports

- \* ENB Annual Report 1989 -1990
- \*\* ENB Annual Report 1991 -1992
- \*\*\* ENB Annual Report 1992 -1993
- \*\*\*\* ENB Annual Report 1992 -1993
- \*\*\*\*\* ENB Annual Report 1993 -1994

The first midwifery degree programme commenced in 1991, following joint validation with the English National Board and higher education. Colleges of nursing and midwifery were required to validate midwifery programmes at a minimum of diploma level (English National Board, 1991). Table 3. notes the progression towards diploma and degree status.

**Table 4. Numbers of students completing diploma and degree programmes from 1995 - 2000**

Date	Numbers of student completing diploma and degree programmes 1995-2000*		
	Total		
1995-1996	Diploma and degree		1377
1996-1997	Diploma and degree		1278
1997-1998	Diploma and degree		1272
1998-1999	Diploma 661	degree 682	1343
1999-2000	Diploma 636	degree 647	1283

\* Figures taken from English National Board Annual Report 1999/2000

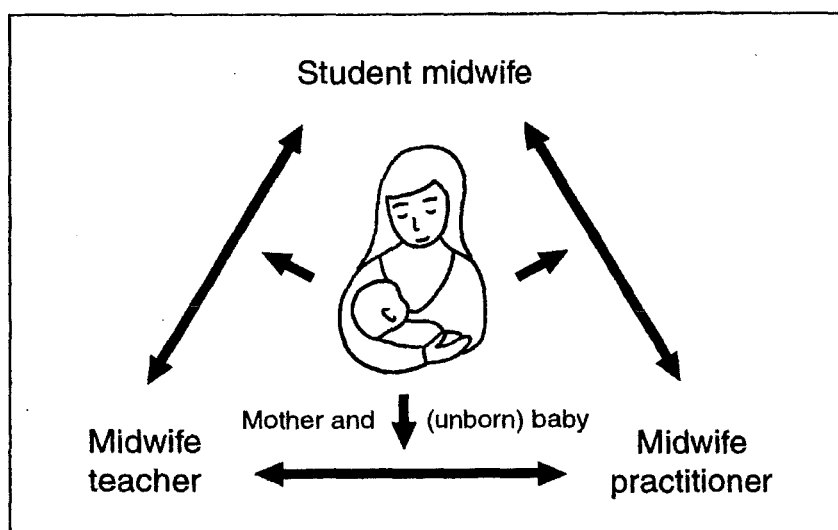
Awards for programmes validated in England in the initial period of links with higher education are in table 4. that demonstrates the progression towards accreditation of diploma and degree programmes.

### **A triangular relationship**

In the early part of this century pupils were taught through obtaining experience in an apprenticeship in practice. Creating a defined role for midwife tutors from the 1950s and the nursing restructuring in the 1970s (Ministry of Health [Salmon Report], 1966) which formalised this role, changed a dual relationship in the apprenticeship mode to

a triangular relationship (figure 6.). At the centre of the triangle are the mother and baby.

**Figure 6: The triangular relationship**



In countries where formal education of the midwife has been introduced and there is studentship, there are three key players: teachers, practitioners and students, in education for midwifery. Each of these persons has a specific role in education. The teacher, as academic facilitator, the practitioner, as practice facilitator, and the student as stimulator of her own learning process. These players form a triangular relationship that, in midwifery, is centred around practical experiences gained in caring for mothers and babies.

### **The teacher - the academic**

As part of the management structure of a maternity unit a midwife teacher was aware of both the clinical and theoretical progress of the student, and was in contact with practitioners. When teachers became employees of higher education, their location was separated from the health services which, in some instances, resulted in a change of their working culture. The position of their role and relationships towards practitioners has changed. They are no longer involved in day to day decision-making

in maternity care. Their involvement is with academia. They meet with students in the academic institution and may not necessarily meet with them in practice. Thus their culture and role has changed. They have a different epistemological background upon which to educate students.

The teacher, when working as a clinical midwife, is accountable to a clinical manager for her practice, but unlikely to directly influence midwifery policy. This alters the previously held relationship between teachers and practitioners. The teacher is a pivot between the teams of professionals engaged in the enterprise of student learning. She is not an instructor but has a special role as a stimulator of student academic and practice achievement. She stimulates the student to acquire capability that Stephenson and Yorke (1998) describe as a fitness for purpose, but which is a fitness that can cope with change and where a person manages her own development. Difficulties in carrying out this role in practice have been identified by Day et al, (1998). In this study Day et al identified a lack of clarity in the lecturer's practice role and question whether it should be either one where the lecturer is a liaison person or a practitioner who is competent in practice. However they indicate that the personal and interpersonal skills are of paramount importance in developing professional knowledge and scholarship that will give guidance to practitioners. They suggest a formalised linked role to clinical sites. This role in practice is, however, only one role of the lecturer.

Midwifery teachers have an educational responsibility for a student's progress, and to assist students in meeting the clinical requirements of the course (European Economic Community, 1983; European Community Advisory Committee on the Training of Midwives, 1991; UKCC, 1998b). Teachers have a responsibility to offer the student both an intellectual and professional stimulus (Barnett, 1990) and to be able to articulate their own critical view of midwifery. Teachers are required to be cognisant of contemporary practices of midwifery and its developments, but may not be able to

demonstrate the same level of expertise in clinical skills and judgement as a practising midwife (Crotty, 1993). In higher education expectations are that they are involved in research, critical reflection and scholarly activity.

### **The clinical midwife - the practitioner**

In each clinical placement area a designated midwife will guide the student, as a mentor, to promote achievement of the requisite clinical skills. The role of the practitioner has been well documented (English National Board, 1991; Butterworth and Faugier, 1992; Morton-Cooper and Palmer, 1993; Aspinall and Siddiqui, 1996; Fraser, 1997, 1998). Midwives in the clinical area are responsible for ensuring that students acquire the knowledge and skills to practice, appropriate to the stage of the course; also to support and counsel students, reviewing their individual requirements. The practitioner midwife also takes responsibility for assessing students' achievements in clinical skills. Her role is multiple, in that the midwife is a friend, advisor, role model, guider and supervisor. The practitioner's accountability is primarily to the clients for whom she has care.

Pressure from within and outside the profession and a review of the midwife's role in the 1980s has led to a change in practices. This coincided with the National Health Service changes and its subsequent reforms (Department of Health, 1992a) and a government review of the maternity services (Great Britain [Winterton Report], 1992). The latter report emphasised the independent role of the midwife whether at home or in hospital. Changes have led to promotion of continuity of care (Department of Health, 1993) with emphasis on choice, continuity and control by women of their own childbirth (Page, 1995) giving confidence to women (Gaskin, 1990), and offering sensitive and sympathetic midwifery care (Flint, 1986). This has meant that midwives have had to rethink their authoritative role which complied with medical opinion.

The practitioner is an important person with whom the student has an apprenticeship relationship for learning the practice of midwifery, but there are subtle differences between the authoritative apprenticeship relationship of the past and contemporary student relationship. Implicit in a student of higher education are skills of criticality and self-responsibility. These are aptitudes that require sensitive handling in relationships between students and practitioners. Negotiation for developing partnerships in learning practice is demanding and needs 'give and take' from both practitioner and student so that they will both identify the appropriate care for the clients.

## **Students**

A minimum of one third of a student's educational programme must be theory and a minimum of one half in clinical practice (English National Board, 1991; English National Board, 1994b). During this latter period students are accountable to their employer. Each student commences the course with her own life experiences that may include personal experiences of maternity care. Personal situations may affect learning and the acquisition of skills by the student.

Two aspects of the curriculum are complementary but may appear to the student to be both opposing and appropriate. The first aspect is the reality of working in clinical practice where a student moves from a position of being totally supervised in clinical practice to having minimal supervision at the end of the programme (Kenworthy and Nicklin, 1989). The level of supervision is dependent on the relationship between the practitioner and the student, and the learning outcomes of the curriculum.

The second aspect of the curriculum is acquiring the knowledge of midwifery. Learning in the educational institution is with the guidance of the teacher. The student, as a student of higher education, is responsible for her own learning, for

negotiating her objectives for her progress throughout the programme and to use skills of reflection (Miller, Tomlinson and Jones, 1994). The overall learning outcomes are linked to terminal theoretical assessments with an obligation to pass. As a student of higher education, there may not be a similar emphasis to achieve the practice assessments (Gerrish et al, 1997). However the importance of a vocational programme is for the student to be capable and to demonstrate ability to translate knowledge within her practice. In these aspects there are ambiguities of balance in curriculum delivery. The study by Fraser et al (1997, 1998,) evaluating the effectiveness of midwifery education programmes defined a model of a level of competence at the outcome of the programme and demonstrated the effectiveness of three year midwifery education courses. The model has three dimensions that are:

- The professional/friend approach - That is, whilst being an autonomous practitioner the midwife relates to the mother as a friend;
- Individualised approach - That is, being able to plan individualised care for women and families, be non-judgemental and advocate for them;
- Clinical competence - Having a repertoire of knowledge and skills, using research-based knowledge and applying dextrous skills, using reflection.

(Fraser et al, 1997, 1998)

Whilst this model and its application has relevance to this study on relationships and learning, the project was concerned with evaluating competence and outcomes of learning. The model was developed to this end, rather than the learning processes in midwifery education. The project was limited to the three year non-nurse programme only. Nonetheless, the abilities embraced by the model are those that a student will aspire to acquire within her relationships with her educators, particularly in practice, in order develop an understanding of the knowledge and skills required in order to be a midwife.

Geographical separation of education from the clinical service means that students receive theoretical insights away from the practical everyday situation, which cannot be related to daily happenings, particularly if students come together for theory from many different health service locations. A primary disadvantage of separation of formal instruction from delivery of practice is a reduction in the teacher's practice role (Day et al, 1998). Advantages of students being taught in central locations of higher education are the breadth of resources available in universities for both students and academics, with facilities of information, research, data resources and information technology. There is also the value of dialogue between students experiencing practice in differing locations. Normative suggested features of studentship based on the above discussion are given below in table 5.

**Table 5: Features of studentship in midwifery**

<ul style="list-style-type: none"> <li>• Clear learning outcomes, with objectives stated in the curriculum</li> <li>• The material to be mastered is cognitive, affective and psychomotor</li> <li>• Students are classed together in groups</li> <li>• The student is responsible for her own learning</li> <li>• The student needs to negotiate within the curriculum her own learning objectives for both theory and practice.</li> <li>• The progression of the student in the programme (including practice) is dependent upon the students negotiation with the teachers (both academics and practitioners)</li> <li>• The student develops skills for reflection and continued learning</li> <li>• The student is approved by terminal examination</li> </ul>
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Adapted from (Friend, 1992)

### **Shifts in control and relationships**

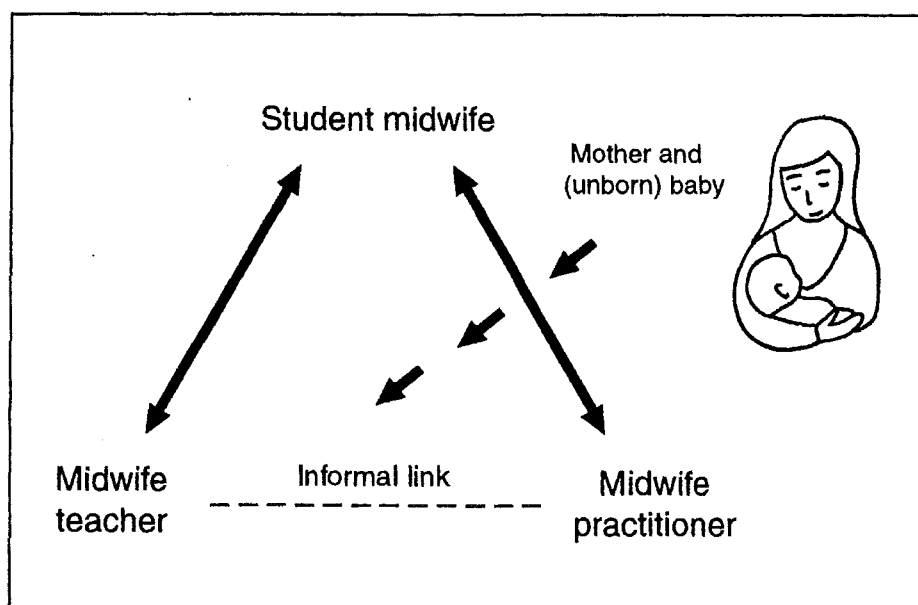
Though the status of the student has altered, she is still in contract for her clinical work to the health service but has gained status as a student within higher education.



Achieving a vocational qualification, which, in part, midwifery is, depends upon clinical skills that require a service commitment. An apprentice model enables this requirement to be met. For a student to be competent to practice both theoretical and practice components of the programme require recognition in the curriculum and terminal assessments that assess fitness for registration require partnership between education and service (Phillips et al, 1994).

Movement to higher education has brought about shifts in roles and relationships of midwife teachers and practitioners, between each other and with students. This has altered the culture and environment for student learning. Altering the employment status of the midwife teacher has resulted in a shift to an association and identification with higher education. There is a tension for the midwife teacher between her responsibility to higher education and her professional responsibility to be perceptive of current practice (Clifford, 1993; Crotty, 1993). Possible models for education are given in the following figures 7., 8., and 9.

**Figure 7: A model with informal links in midwifery education**



————— Formal links  
 - - - - - Informal links

This model indicates an informal link between teacher and practitioner. The mother and baby will not be central to the purpose of each member of the triad. The relationship between teacher and practitioner is weak and the student forms separate links with both the teacher and practitioner. The diagram represents the different positions of the mother and baby in relation to the purpose of each person in the triad. This can be a position off centre within the triangle, towards the practitioner and student relationship or outside the triangular relationship. This will depend upon individual informal relationships between each member of the triad.

**Figure 8: A model with no link between teacher and practitioner in midwifery education**

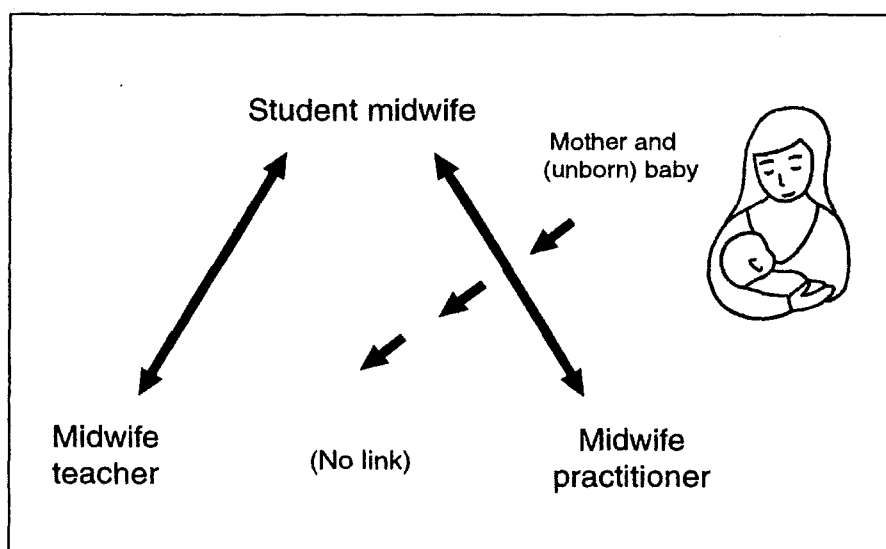


Figure 8. demonstrates no link between the teacher and practitioner. The mother and baby will lie outside the triangular relationship. The teacher does not influence practice and may not have any contact with practice. She will gradually lose clinical skills.

Figures 7. and 8 show shifts from the triangular relationship. The significance in the relationships is the focus of the mother and baby. Instead of being central to the triangle this focus becomes peripheral to the teacher's work.

**Figure 9: A model with formal links between teacher and practitioner in midwifery education**

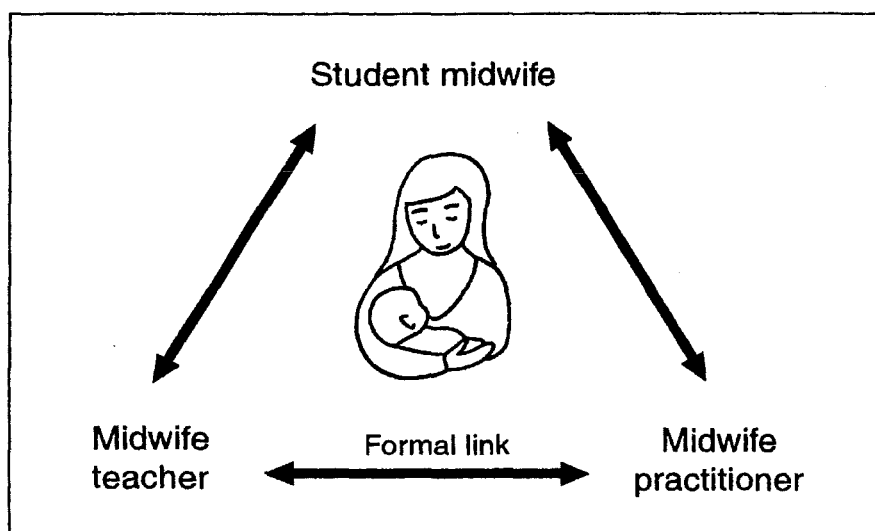
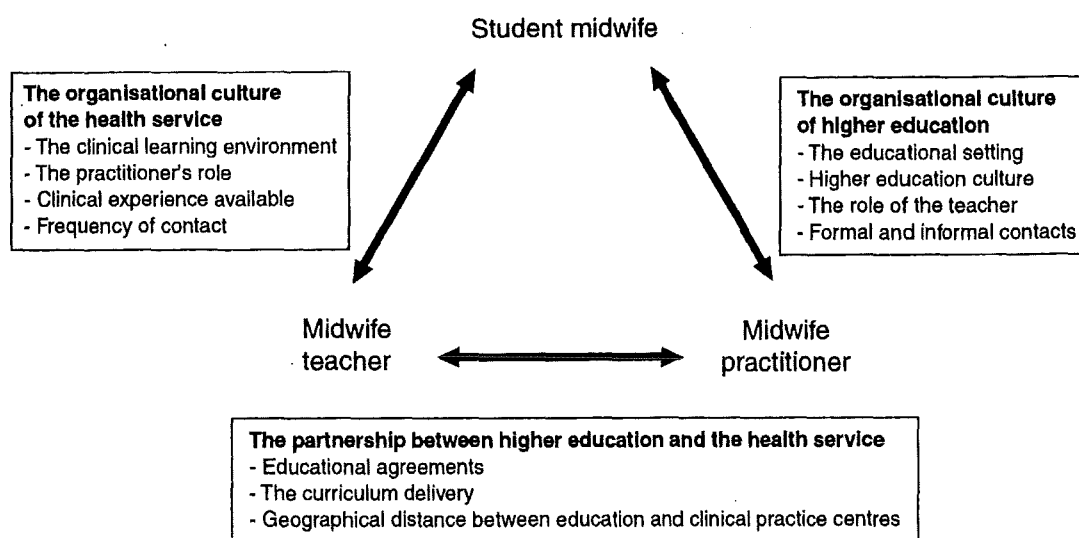


Figure 9. shows a model with a formal link between teacher and practitioner, where the teacher has a role to influence practice and places the mother and baby in the centre of learning. The teacher will maintain a contemporaneous level of practice and the mother and baby will be central to the purpose of each person.

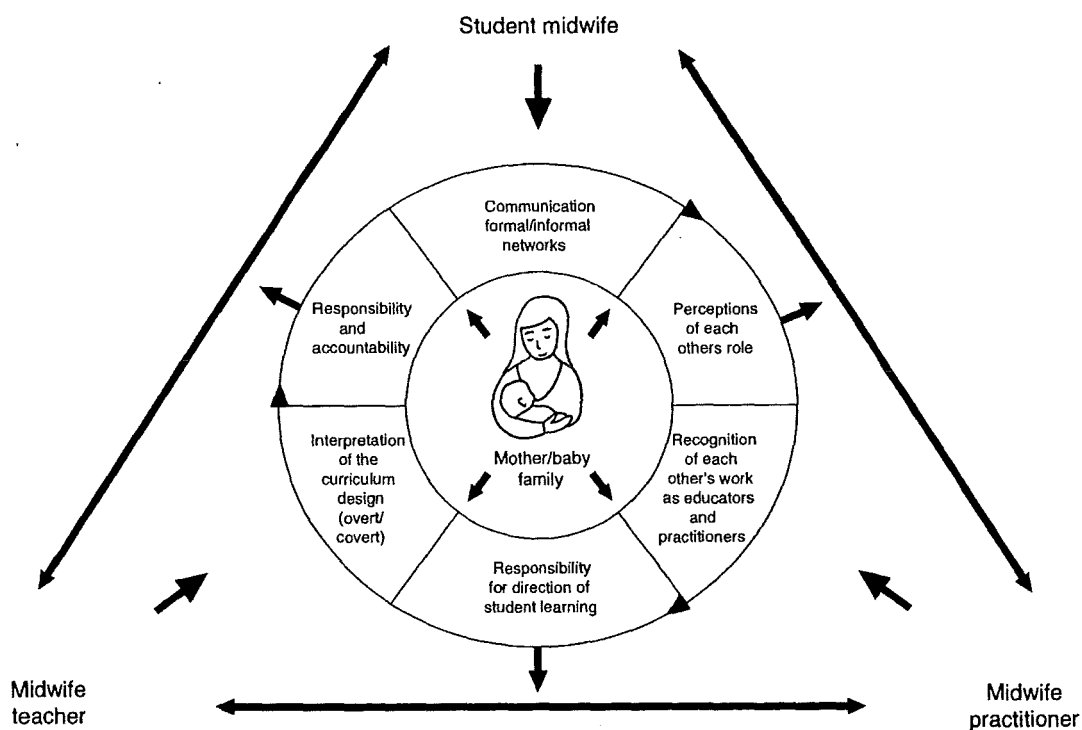
The triangular relationship (figure 9.) is subject to two dynamic forces. One is the external forces which contextualise learning experiences for the student. Within the external forces are three sets of influences that have been mentioned in the preceding text. These three extrinsic influences to the triad will exert pressures and tensions upon each of the groups of the three actors. These are firstly, the culture of the educational centre; secondly, the culture of the health service, and thirdly, the partnerships between higher education and the health services. This chapter has outlined these extrinsic forces through exploring the evolution of midwifery education. These extrinsic forces upon relationships are shown in figure 10 below:

**Figure 10: Extrinsic influences on the triangular relationship**



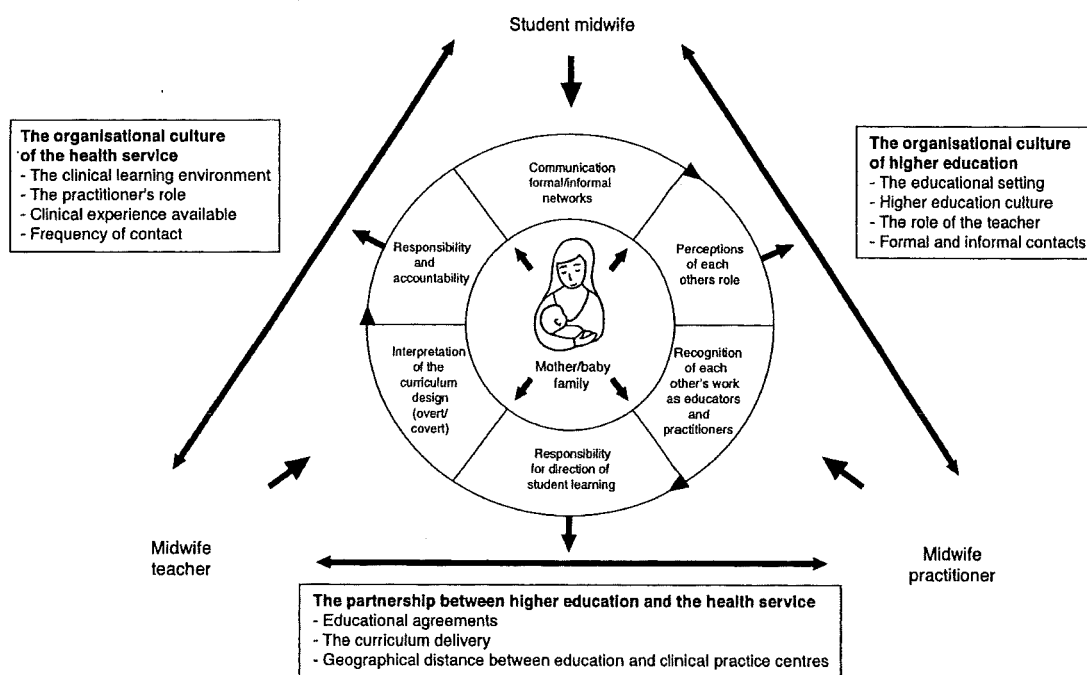
The second set of forces are aspects intrinsic to each of the individual actors. These being communication skills between professionals referred to by Day et al (1998) as personal and interpersonal skills; notions of accountability and responsibility of each professional; personal recognition of the stated curriculum; the partnership between teachers, practitioners and students for the direction of a student's learning; understanding of the work and other's role of each individual. These issues have been raised during the discussions of this chapter. These are person-to-person influences. These aspects are displayed by one person and perceived by the other person and are diagrammatically shown in figure 11. The interpretation of each of these aspects may have a dynamic influence upon relationships between each other.

**Figure 11: Intrinsic influences impinging on the relationships between teacher, practitioner and student**



These two forces, extrinsic and intrinsic influences combine to illuminate the complexity of issues that can alter and shift relationships in learning midwifery as shown in figure 12. (page 66).

**Figure 12: Extrinsic and intrinsic influences impinging upon the relationship between teacher, practitioner and student.**



## Conclusion

This chapter has attempted to provide a background of midwifery education with its context for relationships in learning. Through exploring the history of professionalisation of midwifery and the transition from the mode of apprenticeship to studentship, it can be seen that midwifery has progressed towards professionalism. However, midwifery may not be placed to acquire full professional status because of the vocational nature of practice and an emphasis on partnerships with women. Maybe it should not do so as this could remove it from its position of closeness to women. The knowledge of midwifery is created and developed by its practice with women.

Different possible models of relationships between teachers, practitioners and students demonstrate that teachers who do not have formal links with practice become divorced from the focus of the mother and baby. This results, not only in teachers' knowledge being unrelated to events in practice, but lacks a stimulation of practitioner's and student's knowledge development.

This chapter has set out an initial framework for understanding the character of contemporary midwifery education. Possible models of midwifery education have been identified for exploration. The character of relationships between teachers, practitioners and students has been raised as relevant in student learning. Therefore, relationships between these primary actors will serve as the focus in the explorations to come. The following exploration, in section 2, analyses three dimensions of midwifery education that affect relationships in learning; the characteristics of the profession; midwifery knowledge and the curriculum. These dimensions are fundamental to relationship building between teachers, practitioners and students.

### **3 Learning to be a professional**

#### **Introduction**

The next three chapters, in section 2, analyse the contexts of learning relationships through an analysis of literature. This chapter examines learning to be a professional and explores the areas of midwifery, as a profession, that impact upon student learning. Subsequently, chapter 4, explores the knowledges of midwifery that are gained through relationships in learning the craft of the profession and chapter 5, using an analysis of curriculum documents and literature, explores curriculum issues that impinge upon relationships.

Though midwifery is compared to characteristics of a profession, in this chapter, it is not the purpose to debate issues of differences between occupations and professions, but to compare midwifery to accepted definitions of professions in order to extract an understanding of qualities acquired by students in their relationships with professionals. The term, profession, itself, has many complexities (Friedson, 1994) and its definition evades clarity (Downie, 1990) as no two authorities agree similar definitions (Johnson, 1972).

#### **Professions, professionals and professionalism**

The notion of professionalism provides a basis for the exploration. It is difficult to define its status in this contemporary society because professions, particularly the personal service professions such as social workers (Halmos, 1973a, 1973b), and



teachers (Hoyle and John, 1995), are no longer likely to practice independently, but are more likely to be employees within an organisation (Eraut, 1994).

Within the National Health Service, clients who require health care are served by persons who are both professionals and employees. Ascribing the notion of a professional to a midwife indicates a set of characteristics, such as self-regulation and autonomous decision-making. These characteristics can conflict with the status of an employee, bound by the regulations of a health service organisation, with its own set of policies. The midwife, as an employee, may find a divergence of interest between the legal requirement to comply with policies, which gives a legal autonomy, and a moral autonomy. A legal autonomy is the statutory right to practise independently but to abide by professional and employee legislation. A moral autonomy allows for an ethical decision-making made in agreement with the client. These two levels of decision-making can be at variance, such as when a midwife wishes to comply with a woman's request for a waterbirth at home that directly contrasts with agreed plans of care that can be offered under the Health Trust Policy.

The latter, moral autonomy, is a professional characteristic of making personal but professional judgements on situations in practice. In midwifery, it means negotiating with the client and recognising her rights to make her own choice for her care (Pritchard, 1996). The two forms of autonomy can be in conflict. To develop partnerships with clients is part of a midwife's professional autonomy, thus enabling the client to make informed choices, and being in control of decision-making (Page, 1995). This contrasts with a more paternalistic type of professionalism associated with medicine and law where the professional makes decisions in a client's best interest

(Witz, 1992). Under legislation, midwives have the right to practise autonomously in the event of a normal pregnancy and childbirth (UKCC, 1998b). A student learns to communicate these professional judgements through her relationships of learning when in practice.

Midwifery, as an occupation aspiring to become a profession (Goode, 1969), is comparable to the classification given to nursing as a semi-profession by Etzioni. One criterion for a semi-profession is a shorter length of training than a fully-fledged profession (Etzioni, 1969). The majority of entrants to midwifery have already completed a three year nurse training. Degrees and diplomas are now the route to qualification. Thus midwifery meets more than the requirements for a semi-profession.

The term semi-profession (Etzioni, 1969) is a term that Eraut (1994) describes as ill-defined. Semi-professions, as personal service professions, are likely to be ones in a subordinate role to that of a dominant profession (Eraut, 1994) for example, nursing may be considered to be subordinate to medicine, particularly within an organisational environment. Midwifery, Eraut (1994) would suggest, is a public sector profession and a technically oriented profession that requires a scientific base. Witz (1992) criticises the term semi-profession as a gender controlling concept so as to prevent the semi-professions acquiring full professional status. In her examination of three semi-professions of radiography, nursing and midwifery, each of which have a majority of women, she suggests the term is used to demote their status to occupations subordinate to a male profession. Furthermore, Katz (1969) suggests that medical men are the guardians of scientific knowledge.

Limitations of the role of the midwife were demonstrated in an exploration by Robinson, Golden and Bradley (Department of Health and Social Security, 1983), where the midwife was relegated to routine skills and was in a secondary and subservient position. Though this situation has been rectified with new government reports (Great Britain [Winterton Report], 1992; Department of Health, 1999a), there is still a lack of clarity of the limits of practice (Royal College of Midwives, 1997), with midwives subservient to medical practitioners rather than in partnership. Unless midwives work in full partnership with their medical colleagues, their full role in professional status as the midwife with women is in question.

The claim that midwifery is a 'profession' can be examined through the idea of credentialism. Witz (1992) uses this idea to define professional status. Credentialism in midwifery was conferred on the profession through the Midwives' Act of 1902 defining the entry to the profession and its accreditation. Witz's description of credentialism is 'the use of educational certificates and accreditation to monitor and restrict access to occupations' (Witz, 1992:64). However Witz suggests that midwifery lacks the autonomous state that gives it credentialism, as the profession was under medical control from 1902 to 1979.

### **Becoming a professional**

The route to professional entry is through education and training and as, for many professions, through higher education (Barber 1963; McConnell, Anderson and Hunter, 1962). Higher education is a site in which academics articulate theories and principles for practice. Through academic discourses, the student receives formal views and knowledge of the profession. In observing experienced midwives and

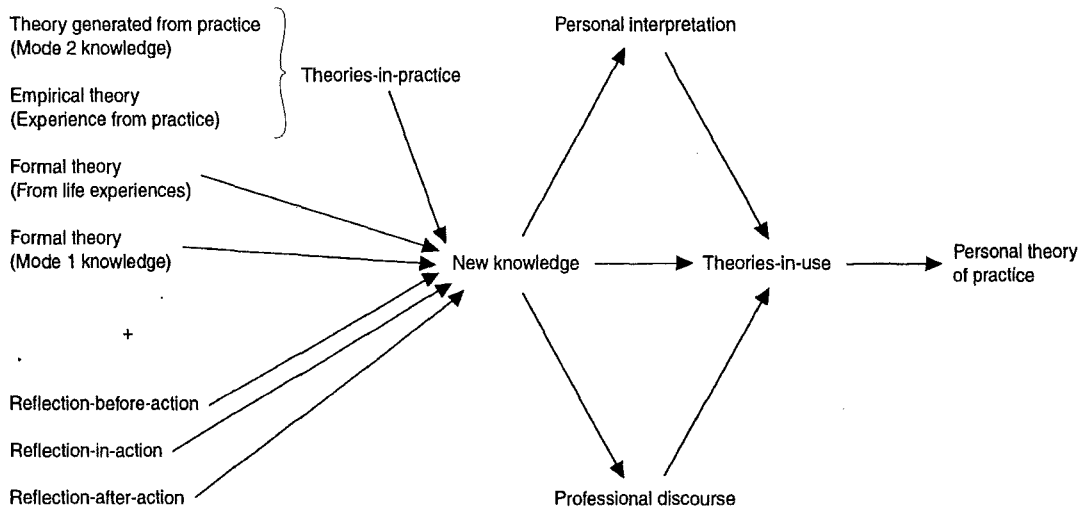
acquiring professional expertise, a student's interpretation of theory in her practice takes place in clinical practice.

In formulating a personal theory of practice, complex interactions take place. In learning to be a professional, the student acquires different forms of knowledge and interprets these through modes of reflection often with positive actions. These are interpreted personally and professionally through discussion that involves the teacher, the practitioner and the student in their relationships with each other. Usher and Bryant (1997) view theory and practice as interactive and mutually enriching. Their discussion demonstrates that practice generates its own theory which is a theory-in-practice and can be compared to Gibbons et al, (1994) Mode 2 knowledge that is complex and is produced within the context of its application.

A new recruit to midwifery has had experiences of life and may have some knowledge of the theory of midwifery on commencement of the programme. New knowledge is conveyed, whether in the classroom or in the clinical situation, through the process of formal theory, with forms of disciplinary or cognitive knowledge, described as Mode 1 knowledge by Gibbons et al. This type of theory could be applied to new information, that is given by the academic or the practitioner, to the student.

Both formal knowledge and a theory of practice enable the student to generate a personal theory of practice. It is through generating a personal theory of practice that learning takes place. Learning is an active process through which the student gains an understanding of the ambit of her professional purpose. Through reflection and reflexivity with questioning her own practice and developing a personal theory of practice the student develops an awareness of critical analysis in learning. Figure 13. offers a simplified representation of the complex forms of a profession's knowledge discussed here, that construct a personal theory of practice.

**Figure 13: A personal theory of practice**



A theory of practice emerges from different forms of knowledge; theories, both formal and generated from practice; experience which formulates a personal empirical theory; reflection and an emerging new knowledge-in-practice. These forms of knowledge will be influenced by the relationships the student has with both teachers and practitioners. It is through the professional discourse of the teacher and the practitioner that the student will be able to make sense of her practice experience. Through her personal interpretation she will evolve her own personal theory of practice.

The process of relating theory to clinical situations can be aided through the process of reflection. The process of and use of reflection for developing understanding and deriving new knowledge is a particularly professional characteristic (Hoyle and John, 1995). Midwifery, as in other professions, such as medicine and engineering, requires skills of cognition which are enacted through affective and psychomotor skills. Reflection may occur before action (Greenwood, 1993) during action, or after action,

using both scientific and humanistic knowledge, and drawing upon other forms of professional knowledge. The use of formal theory, with dialogue between professionals and students, promotes reflection, with an individual responding to each situation. This sets up a continuing process of re-interpretation of knowledge so formulating a developing personal theory of practice.

From their experience, midwives form their own theories-in-use that are evolved from their's and other's actions (Argyris and Schon, 1974). Practitioners and teachers use their formal knowledge in explaining to, and in discussion with students and through dialogue, promote reflection for themselves and their students. Their dialogue will depend upon the form of their relationship. Midwifery students are in a supervised relationship with the qualified professional who knows the traditions of the health service professionals (Eraut, 1994). The student midwife in the midwifery programme comes to understand formal theories underpinning midwifery care and formal theories relating to care that requires intervention. In clinical practice, these two forms of formal theory are not kept separate. These, with theories of practice, are generated through experience and professional discourse. Thus theory and practice are inter-related. In a cyclical process of learning (Bruner, 1977), that develops from experiencing repeating situations in different contexts, use of formal theories and theories of practice help to develop actions-in-practice as the student forms her personal epistemology of practice.

Reflexivity is a further process of reflection-in-action and reflection-on-action. It is an active process developing and evolving theories from a purposeful reflection on current knowledge and experience gained through reflective activity. The practitioner

can assist the student in the active development of this characteristic. Professionals and students share ideas and information through their interactions (Brookfield, 1987). Students watch behaviour and observe how people react to each other, assimilating discourses with other staff and clients. Brookfield (1987) gives examples of these skills, for example, when to listen, when to allow people to think aloud, when to challenge, when to support and when to reflect back what someone is saying. These communication skills may be affected by the interaction of relationships between professional and students through which the student formulates her own evidence for practice.

In addition to the above communication skills, a student midwife learns particular dextrous skills to practise the craft of midwifery, that incorporates knowledge. A professional craft consists of an interweaving of skills with knowledge and activities through repeated actions. By using reflection in subsequent experiences expertise is developed. Midwifery is a craft (Bryar, 1995), with the art being conveyed through human contact. A craft is a form of artistry including its manual dexterity (Webster's, 1986). Its artistry and craftsmanship are strands of women's knowledge that are interwoven into a tapestry with scientific and social science knowledge. Forming a craft of midwifery is essential to provide care for women. Kelly's (1997) view of artistry is that it is creative, expressive, and contains manual skill and dexterity. Creativity and expressiveness also require insight into and comprehension of the surrounding world. Artistry in midwifery includes demonstrating the appropriate behaviour and using professional knowledge in different circumstances and environments, associated with utilisation of knowledge and physical skills. Perfecting practice requires a reformulation of knowledge and utilisation of appropriate skills at

each event. This artistry is developed through gaining new knowledge so as to create a theory of practice through new circumstances.

The professional acts as the role model for the apprentice student, who learns her craft through dialogue between the two (Schon, 1991a). A dialogue of a professional nature brings about reflection-in-action by the student when, through a questioning approach, the professional stimulates the student to reflect-upon-action (Schon, 1991a). In the practice of midwifery, dialogue may occur verbally with actions but can include non-verbal gestures and intimations of body language, with non-verbal communication, which may or may not include the spoken medium. A professional dialogue is one of behaviour, speech and actions exchanged interpersonally.

An imperative is a link between higher education and the health service to form a professional dialogue, to reduce the gap between the special discourses of higher education disciplines (Houle, 1981) and the complex discourse of practice. The accomplishment of practice is multidimensional, as the student acquires skills of practice both with clients and in association with other members of the health professions involved in client care. She can acquire the capacity of knowledge by developing skills in the academy, in the laboratory, or in practice.

### **Midwifery as a profession**

The collective descriptors of a profession's ideology define its the status and betoken qualities that are relevant to student learning and their professional relationships. These characteristics are listed in table 6.



**Table 6. Qualities of a profession used for a basis of comparison**

<ul style="list-style-type: none"><li>• Service to others</li><li>• Professional knowledge</li><li>• Autonomy and self-regulation</li><li>• Responsibility and accountability</li><li>• Code of ethics</li><li>• Standards of practice</li><li>• Control over the curriculum</li><li>• Socialisation into the profession</li></ul>
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### **Service to others**

Downie's (1990) analysis suggests that each profession has a unique and socially valuable function. Whilst midwifery overlaps with other professions, the profession itself is unique, and the social function of midwives is internationally acclaimed (Nakajama, 1997). For some, a profession is a calling or a vocation (Cogan, 1953; Greenwood, 1966; McIver, 1966). This idea implies a total commitment of service to others and one where a person's life work is concentrated in one specific area of that service. Kirkham's (2000) findings suggest that midwives, in giving professional care, discount their personal requirements indicating this sense of service in the midwifery profession.

Goode concludes that aspiring professions will never become 'fully fledged' unless they have a dedication to the public whom they serve (Goode, 1966). Goode offers the idea of this service orientation being based on the needs of the client and not on the

interests of the professional. Midwives have a responsibility to others even when not undertaking contracted hours of work (Dimond, 1997). They have a legal duty of care to women in their responsibility and a professional responsibility placed upon them at all times through the code of professional conduct (UKCC 1983,1984,1992).

Two schemes set up which embody the philosophy of public service are the 'one-to-one scheme' (Campbell, 1995) and the 'know your midwife scheme' (KYM scheme) where continuity of carer and care are the hallmarks of the schemes (Flint, 1991; Flint and Poulangeris,1987). Midwifery-led units (McCourt and Page, 1997) and group midwifery practices offer modified examples of situations where midwives provide a service much more orientated towards women's requirements (Allen, Bourke Dowling, and Williams 1997; Page 1995). In these examples, midwives not only demonstrate their mission of service but also their status as autonomous professionals.

In recent reports from the Government Committee on social services, clients' views and requirements were considered of paramount importance in the delivery of the maternity services (Great Britain (Winterton Report), 1992; Department of Health, 1993). The importance of their views raises issues of partnership with women as a priority for the profession. Within this ideal of service and commitment, Pavalko (1971) indicates a quality of professional trust. Professional trust in midwifery is one of beneficence and non-maleficence to the client and where the professional requires the trust of the women in return, in order to serve in the woman's interest and act as her advocate. Thus, the midwife intercedes with other professionals on a woman's behalf, in the knowledge that this conforms to the woman's wishes (Leap, 2000; Wilkins, 2000). The midwife not only requires the trust of women but frequently the trust of the family as well. This particular quality forms the basis of the relationship between the woman and her midwife. The level of trust may determine interactions and influence the care that is given. A trust relationship forms a sense of vocation and service which is part of the ethic of caring for women.

Downie (1990) suggests that the ideal of service results in an inequality of power between professional and client. To compensate for this inequality requires integrity to balance the legal and ethical role of the professional (ibid.). This power, that can be overt or covert, is shown in language and other forms of communication (Leap, 1992) but can be displaced in the bond of partnership (Downie, 1990). Professional power is one of authority and a privilege (Illich, 1977). In a study of women in labour, women hand this power to the midwife (Bluff and Holloway, 1994), which leads the midwife to taking authority from some women. The balance between empowering and disempowering clients is dependent upon language and interactions (Shirley and Mander, 1996). Verbal and non-verbal language appropriately used can enable women to feel confident and in control. Interpersonal or behavioural characteristics inappropriately used, or used in a way that is negatively perceived, will undermine a woman's trust and confidence (Green, Coupland and Kitzinger, 1998). These skills of relationships between midwife, women and their families are learned within the relationships formed between midwives and students.

### **Professional knowledge**

Fundamental to the evolution of a profession is its knowledge base. Whilst this may have been defined as theoretical foundations (Carr Saunders, 1966), it encompasses a wider view of knowledge, skills and attitudes (Eraut, 1994). The control of the theory and body of midwifery knowledge, (chapter 5), and midwives' capability to practise was held by the medical practitioners (Witz, 1992). Midwifery knowledge was limited in the first half of this century. The authority for midwifery practice in hospital was medically determined. Theoretical foundations of specialised knowledge were influenced by the progress of medical knowledge (Witz 1992; Towler and Brammell 1986). The medical profession has a well developed basis in scientific knowledge,

and during this century midwifery with other professions of the health services have emerged developing their specialised areas of health knowledge. Their knowledge includes the emergence of technology and medicine within the professions of health care.

Women are demanding to know more about their own health and wish to be informed to make their own choices and have control over their care. To offer information and to communicate with women requires sensitive skills of negotiation and responsiveness to individuals (Kirkham, 1989). Sharing knowledge of midwifery with women is part of a professional partnership. Empowering women and enabling them in childbirth, to have control over themselves, their care and decisions, has implications for communication, negotiation and decision making. These skills are encompassed within two dimensions in the model of competence, that is, the professional/friend approach and the individualised approach defined by Fraser et al (1997, 1998) as outcome requirements for midwifery education. This non-scientific element in midwifery complements the scientific base. Etzioni, (1969) in focusing on professions, such as teaching and nursing, states that, there is more emphasis on communication, especially in communicating knowledge. The profession's increase of interest in the subject raises its importance (Leap, 1992).

Professionals develop their own systematic body of theory (Greenwood, 1966). There are areas of midwifery which can be attributed to scientifically oriented theory, which is systematic, but midwifery theory cannot be divorced from social science perspectives. Midwifery, throughout the centuries has been handed down through customs and ritual practices (Donnison 1988; Towler and Brammell 1986).

Knowledge of a profession is conveyed through its language, though there is criticism that the profession's language becomes obscure (Downie, 1990). Midwives sometimes use medical terminology and mystify their practice by using language that

is arcane and thus disempowers the client (Kirkham, 1989). Alternatively, they can communicate with women by using language which women understand. Using the language of the people forms a bond of partnership, shown by Benoit's exploration of the midwifery profession, in observing traditional birth attendants in Labrador. This contrasts with the use of professional terminology. Benoit (1989) suggests that midwives working with women gained a local knowledge of the people. Those educated through academic institutions gain a theoretical understanding of midwifery (Benoit, 1989). This raises the importance of women sharing in the knowledge of their birthing and being in partnership with midwives (Benoit, 1994). This notion of partnership conflicts with the traditional pre-suppositions of a profession based on patriarchal constructs (Witz, 1992).

An important dimension of becoming a professional is that of gaining a mastery of complicated operations and skills (Greenwood, 1966), though these skills are gained in conjunction with an application of a systematic body of theory. The nature of midwifery is that many activities involve situations that are not accepted in other circumstances but the professional, with consent from the client, can enact skills that would otherwise be taboo (Johnson, 1972).

Skills in midwifery emanate from the knowledge of women and are woman oriented, but midwives today use medical and technical skills to augment their craft. Like other professions, new recruits learn through an initiation into the culture and practice of the profession. The midwife's mastery is knowing, not only her craft but knowing what, when and how and to share appropriate knowledge with women. An emphasis on antenatal and prenatal education underlies the importance of sharing relevant knowledge with women. Professional knowledge of midwifery is not only maintaining the specialist knowledge and power but *knowing what* should be shared with clients.

## **Autonomy and self-regulation**

There are two levels of professional autonomy (Eraut, 1994). One is that of professional control. Formerly midwifery, as we have seen, could have only been considered partly autonomous and partly self-regulating as a profession. Now, as part of the United Kingdom Central Council, midwifery is in a position of being a partner in the formation of national policies affecting nursing, midwifery and health visiting. There are differences between nursing and midwifery. Policies relevant to nurse education determined at both national and institutional levels, may not necessarily be appropriate for midwifery such as the implementation of a higher level of practice considered appropriate for nursing (Lewis, 2000). This influence can lead to some lack of control by the midwifery profession over its education continuing its role of partial self-regulation.

The second level of professional autonomy (Eraut, 1994) is individual. Here, the individual practitioner enjoys a level of responsibility for making judgements. This gives the practitioner autonomy that Kaplan Daniels (1973) considers to be part of professionalism. The autonomy of midwives examined in Robinson, Golden and Bradley's study (Department of Health and Social Security, 1983) offered evidence that midwives were limited in their sphere of activity and their level of control in decision-making, being subject to stated policies. This view, that midwives lack autonomy, is reiterated by Clarke (1996a). The autonomy that midwives have in practice varies across different health authorities in the United Kingdom and from country to country (European Midwives' Liaison Committee, 1996). Some midwives work in midwifery-led schemes where they have the freedom to take decisions in partnership with women (Page, 1995).

Professionalisation occurs when an organised occupation has control over its training and has exclusive rights to perform a particular kind of work (Friedson, 1973). The professional controls and evaluates the way in which work is performed. Friedson's contention is that professionals control the work that they do, but the autonomy of the midwife is constrained by her contract of employment and by others, such as, managers who may control the resources and the boundaries of the work.

Midwives vary in the extent of their control of the decisions they make and the degree to which they conform to institutional policies (Garcia and Garforth, 1991). Clarke (1996b) suggests that midwives acquiesce to medical control thus demonstrating the power differences, but midwives have other constraints upon their work, such as management expectations and peer norms which frame their freedom to make their own decisions.

### **Responsibility and accountability**

A professional's responsibility and accountability are not clearly differentiated, but responsibility has a wider meaning entailing a voluntaristic commitment to principles which govern practice (Hoyle and John, 1995). Responsibility includes a commitment to broader areas than specific professional actions to the client and her care. It includes accountability for results of actions or non-actions (Hoyle and John, 1995). Responsibility has connotations of the further interests of the client beyond the confines of the 'duty of midwifery care' (Dimond, 1997). It enables the professional to make judgements and take decisions, making choices in her actions and relationships with others. Responsibility is being involved with the clients' wider family; or taking actions in relation to other team workers, such as students, peers, and other staff. Hoyle and John (1995) relate this notion of responsibility to professionalism, which is a process of *extending the professional*. This level of

responsibility, in turn, extends the professional's autonomy where choices of action are made in relation to clients and other professionals (Hoyle and John, 1995). The midwife has a responsibility to the client for the care given (Roch, 1992).

Within professional-to-client accountability, there is control by the client over the practitioner's practice (Adelman and Alexander, 1982). In midwifery, moral accountability to the client is important but the midwife has a responsibility in gaining the confidence of women and their families working in partnership towards decisions regarding care, in ensuring the safety of mother and baby.

Eraut (1994) offers two modes of accountability. The first is personal and professional that is a moral accountability to the client, which, for midwives, includes enabling the mother or parents to participate in decisions and choice regarding their care. Midwives are answerable to the client for their actions and decisions (Hunt, 1992). Women and families' choices can conflict with the ideal of safety. Where there is conflict, the midwife uses interactive skills of diplomacy, tact, persuasion and power to reach decisions reflecting both her own accountability as a professional and employee and her moral accountability to the woman. The UKCC code of professional conduct makes it evident that all midwives are accountable for their practice (Dimond, 1994).

The second of Eraut's ideas of accountability is to the stakeholders. This accountability is a wider professional accountability which gives a service to the client, but it includes an accountability to the employer and to the peer group of the professional team, as a form of mutual accountability. Accountability is complex in that the midwife also has a formal line of accountability to her employing organisation, which has a potential to conflict, with professional accountability (Eraut, 1994). Dilemmas exist when there is divergence of views between personal, professional, employee, and mutual accountability.



## **Code of ethics**

A code of ethics provides a client with protection, and serves as a guide to the professional. Implicit in the early midwifery legislation were standards of practice to protect the public. A code of ethics is one of the hallmarks of professionalisation (Carr Saunders, 1966); and a code of ethical standards is of paramount importance in health care where the public require protection against malpractice. A code that is self-regulating is altruistic and public service oriented, and guides the profession's self-discipline (Greenwood, 1972).

Midwifery complies with this characteristic (Great Britain, 1902) having a statutory body controlling midwifery and setting rules. This body was the Central Midwives' Board (1902 -1983) and from 1983 the United Kingdom Central Council. In the United Kingdom, midwifery has a set of rules and a code of practice (UKCC 1983, 1984, 1992; UKCC, 1998b). The importance of ethical considerations in care are reinforced by the international code of ethics for midwifery (International Confederation of Midwives, 1993, 1999) which offers midwives guidance.

## **Standards of professional practice**

The purpose of explicit standards is to protect the public. Such standards of practice are enshrined within the definitions of a midwife (World Health Organization, 1992) and the role of the midwife (UKCC, 1998b). Regulating explicitly stated standards of practice is multifaceted. One form is the supervision of midwifery which ensures a national standard of practice. In contrast to other professions, including nursing, midwifery has its own self-regulating mechanism to control midwives' practice through the statutory supervision of midwifery. It is enacted through legislation and

the implementation of the midwives' rules and the midwives' code of practice (ibid.). As mentioned previously, midwifery supervision is peculiar to the profession, with supervisors of midwives at all levels in the health service ensuring that the public is protected through standards of midwifery practice.

A recently introduced annual audit of maternity units in England (English National Board, 1997) not only enables the English National Board for Nursing, Midwifery and Health Visiting to have an overview of the national standards of practice, but gives midwifery units opportunities to reflect on different approaches and choices in giving care. A further standard is evident in the government's requirements to conduct audits and monitoring of quality (Great Britain, 1997a). This has been introduced through risk management assessment and development of policies and practices (Department of Health, 1992b). Each Health Trust is responsible for the quality of its maternity service.

Professional practice has two safeguards that acts as standards. These are the standards of entry to the profession and an emphasis on regular professional updating. All midwives are required to undertake a five yearly refresher course and from 2001 will have to meet the continuing professional development standard set by the United Kingdom Central Council, for Nursing Midwifery and Health Visiting in order to maintain registration (UKCC, 1999a). The professional standards influence the environment in which a student learns.

### **Control over the curriculum**

Professional control over a body of knowledge and curriculum is another symbol of a 'profession' (Becker, 1962). The midwifery curriculum was laid down by the Central Midwives' Board and this was devolved to midwifery training schools in 1987. This

can be a problem in the university setting (Anderson et al, 1962) where a profession may not be in a position to dictate its own standard and content for delivery of a course programme. This reduces its professional control over the curriculum (Eraut, 1994).

Involving practitioners and students in developing a curriculum promotes its relevance to practice. The English National Board (1996) recommends consumer representation in course planning. This is endorsed by Fraser (1999b), who suggests that women may contribute to a curriculum, which is planned for its locality. It is also a requirement of the English National Board to develop a curriculum that involves both practitioners and teachers, but should also include students in the decision-making (English National Board, 1994b).

### **Socialisation into a profession**

The craft of the profession, is learnt by a student who integrates the theories and characteristics of the profession with her experience of practice. The student as a novice within the profession undergoes a period of pupillage (Eraut, 1994) where the trainee gradually acquires her craft. Theories and characteristics are learned and acquired through being with other professionals and through relationships formed (Olesen and Whittaker, 1970). The student in the clinical situation is exposed to a range of experiences through which she is culturally conditioned to the profession (Olesen and Whittaker, 1970). This is a developmental process: for example, in learning the differences of culture between hospital midwifery and community

midwifery the student will first encounter an experience in one environment, and then may repeat this experience. She will then move to another environment where situations of a similar nature are experienced but she may have to learn different styles of language and ways of practice to undertake the same care, thus adjusting her professional behaviour.

Cultural conditioning occurs with the 'continuities and discontinuities' in experiences in 'which some concepts can be sharpened and clarified.' (Olesen and Whittaker 1970: 189). Cultural conditioning occurs through exposure. The student is exposed to apprenticeship relationships in the health care setting, and to relationships with academics within higher education. Exposure in both the higher education and health service settings brings repeated experiences albeit of different kinds. Learning different frames of reference, through which the student is socialised to the differing norms of the professional culture, is by a gradual process of being conditioned to each experience.

Midwives base their practice on their own personal wealth of experience, which is built up by working with professional colleagues, and through individual personal education and development. They develop strategies through reflection by taking decisions for their actions-in-practice. These affect the quality of life or could be life saving for mother or child. This is a type of intuition, developed from reflection and can be combined with 'playing hunches and informed guesswork' (Brookfield 1987:152). Benner (1984) describes the progressive acquisition of skills using intuition based on experience. An example of using these skills is listening repeatedly to recognise a normal pattern of the fetal heartbeat and the learning to detect the

variations that suggest abnormalities. Thus, using skills in repeated experiences, collective information informs personal intuitive actions in further practice to detect normal and abnormal patterns. Though Benner's framework does not include the socialisation processes that occur in this process of learning, her framework is used in curricula for the education of midwives.

Adjustments to the characteristics and culture of a profession are made through relationships that students develop in clinical practice. The curriculum for midwifery education brings about the socialisation of the recruit to the culture of the health service and the culture of midwifery, both of which have their own rituals and traditions. The student is socialised to the profession in three ways, all interlinked.

Firstly, the student is socialised through a working with a mentor, a clinical midwife, on a one-to-one basis. This is where the student learns the standards through interactions by which she may adopt the professional qualities. Learning by experience will occur through actions and assimilation whilst being supervised by a mentor. Secondly, the student learns from both the teacher and the practitioner the formal knowledge of the professional, and the legal and ethical requirements of practice, which generate frames of reference for her professional role. This is learned through formal modes of education.

Thirdly, the student is required to become familiar with the practices outside the normal mores of society, such as requesting intimate information and undertaking practices which are normally taboo in society, such as observing and touching normally unexposed and intimate parts of the body. The student learns the expected codes of behaviour and attitudes of experienced midwives, and through these, reforms her own stance in relation to professional expectations. Thus, she learns theories

generated from practice (figure 13., page 73). Students, as new recruits learn professional responses to women, for example, in the labour ward when women demonstrate pain in labour. The student will learn ways of talking, touching women and responding to women in ways that are not normally accepted when meeting women in other circumstances. Students may also review their understandings of pain as a women's responses to labour pain may differ from their previous expectations of pain responses. Within this process students alter their own moral and ethical behaviour. These processes are learned through experience and interactions in practice. This socialisation process results in changes in personal and cultural understandings (Olesen and Whittaker, 1970), whereby the student becomes the practitioner as professional.

## **Conclusion**

It is in working with clients that students acquire the attributes of a profession and evolve their own knowledge-in-practice. Midwifery seeks to achieve partnerships with women and its practitioners work as professionals with and in their association with clients. Students acquire the qualities and knowledge that are unique to the profession.

In learning to be a professional relationships are not singular and students form many different kinds of relationships with professionals as part of the process of induction to the profession. The academic institution may be the entry to the profession and promote the theoretical bases of the midwife's knowledge, but it is within the clinical

setting, alongside the practitioner that the student learns to develop her own practice, making sense of the concepts and characteristics of the profession.

It is through relationships of learning that students assimilate the culture of a professional and acquire the rules of the craft. The practitioner is the role model for the student, whereas the teacher guides the student to the sources of knowledge and in her thinking. Both, in their relationships, influence students' acquisition of professional qualities. The student, through acceptance of the course programme, has made a choice to aspire to become recognised within a profession. Recognising the professional qualities and displaying them confers acceptance by others within and without the profession. Students of midwifery are learning both the professional role of the midwife and the art of midwifery practice.

The above discussion in reviewing the characteristics of a profession has illuminated the process through which a student is inducted to the profession. The next chapter turns to reviewing the types of knowledge acquired by a student to form her craft.

## **4 Midwifery knowledge**

### **Introduction**

Contemporary knowledge within our society is not static. It contributes and responds to technical, scientific and humanistic developments, frequently promoted through the commercial world, and, in health care, through a medical and scientific world. A society's view of a health service profession is dependent upon people's expectations of that profession's knowledge and expertise. This chapter seeks to elucidate the types of knowledge fundamental to the practice of midwifery.

Knowledge within the midwifery profession is driven by seven orientations of contemporary society. First, midwifery was traditionally a domain of women (Tew, 1995) and though this domain has been altered and reduced through the centuries (Arney, 1985), there is a public expectation that midwifery is mostly a woman's role. Second, medical definitions of midwifery and obstetrics, promoted in the health service and the media, are founded primarily on a rational technical approach to knowledge and knowledge production. A rational technical approach to knowledge is based on knowledge, characteristics of which are found within the sciences, that are systematic, and bounded within specialities (Schon, 1991b). Thirdly, there is a public expectation of midwifery and medical safety that will provide a healthy outcome for mother and baby in childbirth.



Fourth, emerging women's organisations, such as The National Childbirth Trust and The Association for Improvement of the Maternity Services, promote women's views and their expectations of childbirth, particularly from an anthropological and feminist perspective. This places emphasis on phenomenological understandings of childbirth, which requires midwives to interpret the meanings that women have for their own birthing experience. There is also an emphasis on information giving and women's choice.

A fifth characteristic is that of a health service which has a market/consumer orientation with healthcare services responsive to economic changes (Warde, 1994). This health service determines parameters within which a midwife functions, prescribing the scope of her knowledge and the areas to which she may transfer her knowledge. Sixth, are political demands for an effective, efficient and evidence-based health service, achieved through quality controls and auditing mechanisms and which is associated with client rights, and public charters (Great Britain, 1997a). Finally, there is an incremental academic drift of midwifery education. This perforce, is moving midwifery from being a vocation based on traditional knowledge with skills to a profession with academic credit with knowledge based on evidence and scientific thought. These seven characteristics offer a complex terrain for relationships in midwifery education with profound forces affecting knowledge development and its acquisition.

## **The character of midwifery**

Midwifery is more than a combination of knowledge (Bloom, 1956), skills (Bloom, Krawthohl and Masia, 1964) and attitudes (Simpson, 1966). Midwifery skills cannot be put into place without knowledge, thus forms of knowledge are a part of and interlink with skills, and are within their development (Eraut et al, 1995). It is a complex activity, which interweaves these constructs with intuition gained from wisdom (Midgley, 1986) and experience, but it also comprises an understanding of a human interactions, which is part of its artistry.

Polanyi describes the art of knowing as tacit but with an objectivity through replication. By relying on personal powers of knowing, individuals know how to adjust and manoeuvre. An art is passed from person to person through personal contacts (Polanyi, 1958).

This chapter explores knowledge domains of midwifery using a threefold typology presented by Eraut (adapted in table 7). This typology of propositional, personal and process knowledge is used as a framework for discussion, to which is added a further domain of knowledge described as interpersonal knowledge (table 8.). This analysis is to determine the domains of knowledge that students acquire.

**Table 7: A map of three areas of professional knowledge**

<u>Knowledge forms</u>	<u>Types of knowledge</u>	<u>Examples of knowledge</u>
<p>PROPOSITIONAL KNOWLEDGE</p> <p>'Knowing That'</p>	<ul style="list-style-type: none"> <li>Scientific Knowledge</li> <li>Professional Knowledge               <ul style="list-style-type: none"> <li>- Espoused Knowledge</li> <li>- Theoretical Knowledge /Conceptual Knowledge</li> <li>- Codified Knowledge</li> <li>- Knowledge In Practice</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Disciplined based theories               <ul style="list-style-type: none"> <li>- research</li> <li>- evidence</li> <li>- scientific theory</li> </ul> </li> <li>Systematised knowledge</li> <li>Generalised principles of the profession               <ul style="list-style-type: none"> <li>Textbook knowledge</li> <li>Reflective knowledge</li> <li>Published knowledge</li> <li>Public knowledge of the profession</li> </ul> </li> <li>Specific propositions about decisions and actions</li> </ul>
<p>PERSONAL KNOWLEDGE</p> <p>Personally 'Knowing How'</p>	<ul style="list-style-type: none"> <li>Experiential Knowledge</li> <li>Tacit Knowledge</li> <li>Intuitive Knowledge (personal intuition based on personal knowledge)</li> <li>Knowledge of People</li> <li>Uncodified Knowledge</li> </ul>	<ul style="list-style-type: none"> <li>Interpretation of experiences events, activities</li> <li>Observational knowledge               <ul style="list-style-type: none"> <li>- impressions</li> </ul> </li> <li>Personalising codified knowledge - self knowledge</li> <li>Personal judgements and decisions</li> <li>Social interactions</li> <li>Non verbal behaviour</li> </ul>
<p>PROCESS KNOWLEDGE</p> <p>'Knowing what to do in procedures'</p> <p>( combining knowledge with skills)</p>	<ul style="list-style-type: none"> <li>Procedural Knowledge</li> <li>Deliberative Processes (Links To Competence)</li> <li>Control Knowledge               <ul style="list-style-type: none"> <li>- Metaprocsees</li> <li>- Skilled Behaviour</li> </ul> </li> <li>Situational Knowledge               <ul style="list-style-type: none"> <li>- Acquiring Information</li> </ul> </li> <li>Translation in Action</li> </ul>	<ul style="list-style-type: none"> <li>Planning, problem solving, decision making, analysing ,evaluating - knowledge of context and situation and problem</li> <li>Conceptual realisation of practical course of action decision options</li> <li>Controlling one's behaviour</li> <li>Self management : reflection - analysis and evaluation</li> <li>Differentiating between the account and the action</li> <li>Directing courses of action</li> <li>Reading the situation</li> <li>Information exchange               <ul style="list-style-type: none"> <li>- giving information</li> <li>- listening</li> </ul> </li> <li>Intuitive processes based on experience and patterns (Benner 1984)</li> </ul>

(Adapted from Benner, 1984; Eraut, 1990; Eraut and Cole, 1993; Eraut et al 1995; Polanyi 1958) \_

**Table 8: A fourth area of knowledge: Interpersonal knowledge**

<p>INTERPERSONAL KNOWLEDGE</p> <p>‘Knowledge-in-use’</p>	<ul style="list-style-type: none"> <li>· Midwifery Ethical Awareness <ul style="list-style-type: none"> <li>- self knowledge</li> <li>- ethical responses in relationships</li> </ul> </li> <li>· Professional Ethical Responsiveness</li> </ul>	<ul style="list-style-type: none"> <li>· Awareness of others ‘Attending to the awareness’ (Polanyi, 1958) of the situation and responding to it</li> <li>· Being empathetic</li> <li>· Moral behaviour and ethical responses in relationships</li> <li>· Using appropriate behaviour intuitively</li> <li>· Recognising women’s self knowledge</li> <li>· Forming relationships with others spontaneously</li> <li>· Promoting interactions with women</li> <li>· Responding to and articulating skills to others</li> </ul>
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The term knowledge is used in its wider context (Eraut, 1994) which includes skilled behaviour and practice knowledge (Eraut, 1992). This is knowledge of a cognitive and tacit nature that is involved in performing skills with behavioural and attitudinal aptitudes. The term within this text refers to tacit forms of knowing, and interpretations of knowledge within actions and practice (Polanyi, 1958). Although midwifery, in part, conforms to the domains of knowledge discussed by Eraut (1994) as propositional, process and personal knowledge, differentiating knowledge types can make artificial boundaries. The above classification also does not include ‘attending to the awareness’ (Polanyi 1958:8) which is a form of responsive behaviour to the actions of others.

This responsive behaviour in midwifery is with women. This is an active thinking process, frequently occurring between people, but which is beyond the idea of 'getting on with people' (Eraut, 1994). This fourth area of knowledge (table 8.), is explored within this chapter as interpersonal knowledge, and offers an understanding of wider and sensitive areas of midwifery. In their examination of a portrait of a professional Day et al (1998) identify interpersonal and intra-personal qualities that are part of Eraut's personal knowledge. The interpersonal knowledge suggested here is the knowledge that is exposed in caring for women, that is part of a responsiveness concerned with an ethical behaviour and identified in interactions involving the inter-subjective self.

The differing strands within tables 7. and 8. together form the knowledge of a midwife's craft. A division between skills and knowledge is artificial, but for the purposes of this text they are separated to explore, in some detail, an understanding of midwifery knowledge. Skills not only include complex knowledge forms but are themselves a form of knowledge through using appropriate interpretations of behavioural and attitudinal actions.

## **Propositional knowledge**

Fundamental to any profession is its scientific and professional knowledges, that is, its propositional knowledge (Eraut et al, 1995).

## **Scientific knowledge**

Scientific knowledge can be objective or interpretive; both of which are identified through different research paradigms. Theoretical knowledge, advanced by teachers, consists of both scientific knowledge, a form of objectified and generalised knowledge and interpretive knowledge, that recognises human complexity and human experiences. When clinical midwives apply scientific knowledge to situations in practice they engage in active discussion of its applications within a practical situation (Eraut et al, 1995).

Midwifery incorporates scientific knowledge, described as Mode 1 knowledge, that is knowledge generated within a discipline which is cognitive and contextual (Gibbons et al, 1994). Without theories sustained through public enquiry, as represented by the sciences, a student would not fully be able to understand the skills of midwifery. The influence of a medical epistemology has predominantly caused midwives to embrace positivistic examples of knowledge. The term positivistic is used in this context as the orthodox approach to scientific enquiry and its modern interpretation, rather than the different collective meanings, such as Comtean positivism, logical positivism, behaviourism and empiricism (Hughes, 1990). Each of these views of positivism pervade certain sciences and can be found within the scientific writings and practice of obstetrics and midwifery.

Scientific thought was founded on logical enquiry (Hesse, 1974), in which knowledge is objectified, (Maxwell, 1984) and reduced to parts. Reductionism, which reduces a whole object to its parts, results from objectifying knowledge (Nozik, 1982). This type of knowledge was considered the purest form of knowledge (Kerlinger, 1979) and obstetric knowledge was founded on this type of scientific enquiry (Oakley 1979). Kerlinger (1979) gives two characteristics of science which are (a), objectivity and (b), its empirical nature. His view is that science is based on controlled observations which are not distorted by personal views. This may be applicable to the hard/pure disciplines (Becher, 1989) but midwifery is also based on personal and process knowledge with a responsiveness to others.

Midwifery knowledge based on evidence and enquiry relies on obstetric knowledge for developing practice, which is effective and safe for the care of the mother and baby. Table 9. shows examples of advances resulting from scientific enquiry:

**Table 9: Examples of enquiries in midwifery practice**

- |   |
|---|
| <ol style="list-style-type: none"> <li>1. Perinatal mortality enquiries that give indices of the key issues in reducing the rate;</li> <li>2. Analysis of comparative methods of managing the third stage of labour safely;</li> <li>3. Healing of the perineum;</li> <li>4. Dietary requirements for a healthy pregnancy.</li> </ol> |
|---|

These examples are not given in any priority order

Midwifery depends upon scientific knowledge to advance understanding of skills, especially technical developments. Scientific knowledge develops new technologies and skills. A science of midwifery is essential to understand forms of care, as in the management of pain relief. Scientific enquiry has led to technological advances and has produced a greater understanding of the mechanisms of the processes of birth and care. Rigorous methodologies offer an improved understanding of the human process (Chalmers, 1983). Midwives are developing their own scientific bases of knowledge in collaboration with other health professionals, for example, in explorations of appropriate antenatal care. An epistemology of midwifery will evolve from integrating complex forms of knowledge.

Objective forms of enquiry are limited. They may ignore the human responses in maternal care and the particularities of individuals. They do not encompass social, cultural, and spiritual qualities, which are all part of human nature. Neither do they allow consideration of ethical principles, for example, when a new birth occurs within a family and a conflict arises out of an unexpected abnormality. Care of a pregnant woman can be split into component parts for completing segments of activities for example: genetic analysis; biophysical status; obstetric assessment; blood and urine assays, though none of these activities on their own give a complete personal profile of the health of a woman. To reject all evidence-based enquiry using a reductionist design would limit the growth of theory of the profession, particularly in application of the hard disciplines, but to confine knowledge to such a field ignores the context of a woman's life.



Differences in forms of knowledge are acknowledged by Midgley (1986), who disputes the view that objectified knowledge is the only knowledge and argues for respect and understanding for life as a whole. Views of women, who receive maternity care, are that they not only require physical care but human understanding and respect for themselves (Hutton, 1988, 1994). Scientific enquiry derived from an interpretive or descriptive approach (Lincoln and Guba, 1985) that encompasses surrounding phenomena, with humanistic elements provides a view of complex experiences (Boudon and Bourricand, 1989). This type of enquiry includes socio-cultural views that can be applied to midwifery. In complementing a reductionist approach, descriptive and illuminative methodologies describe phenomena that give contextual descriptions.

An enquiry may seek women's views of a particular experience before deciding upon a line of action to take. The nature of care for childbearing women may be more clearly recognised through forms of interpretive enquiry which analyses the discourses of women. Motherhood is a social phenomenon and women's priorities for their care may differ from the assumptions of professionals, for example women may be concerned about 'something that is medically trivial but socially serious.' (Perkins, 1991).

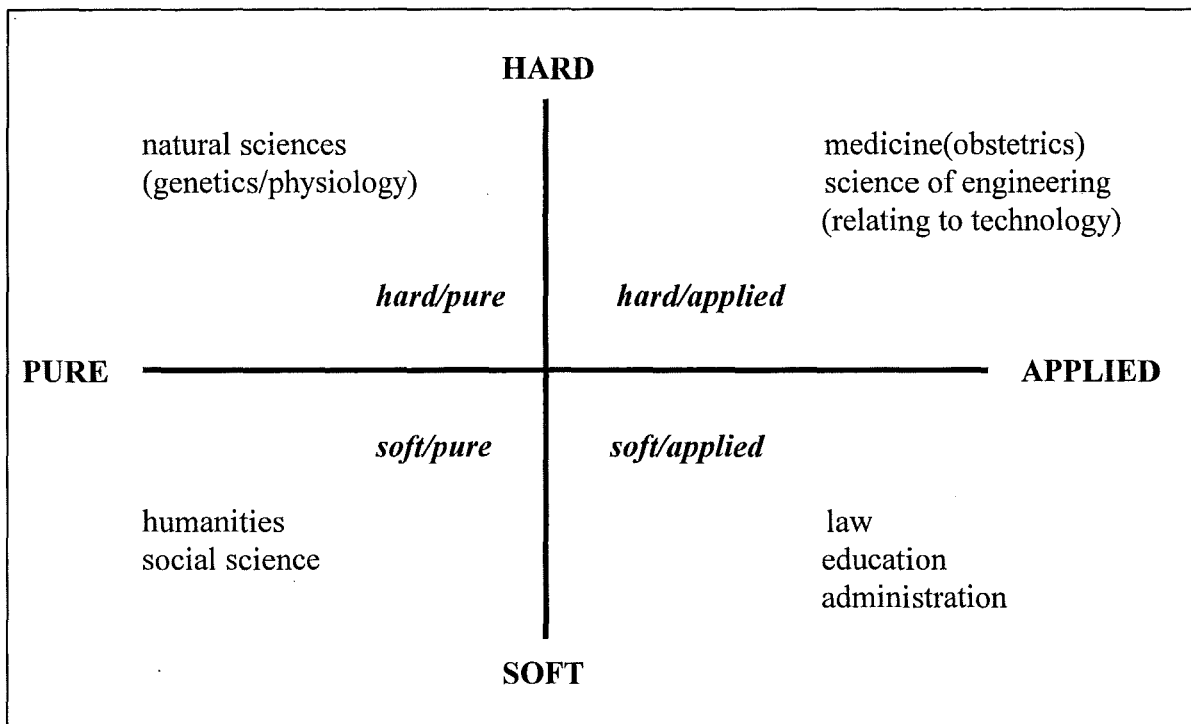
There is a difference between knowledge based on facts which offer evidence, and knowledge based on experience emanating from social interaction and relationships forming behaviour (Enkin et al, 1995). Sources of knowledge also emanate from interpretation of social meanings (Carr and Kemmis, 1993), which is interwoven with scientific knowledge. Thus,

midwives utilise a complex range of knowledges and skills to practise (Rogers, 1991). A science of midwifery practice is difficult to articulate, though new kinds of research could map the knowledge of midwifery for this reason (Wallen, 1984).

### **Professional knowledge**

Academic understanding of midwifery is multidisciplinary and crosses diverse boundaries. By its very nature, it traverses the different sciences and applies these to the specific care of woman and child. There are different ways of classifying professions that are eclectic, such as midwifery, that traverse many academic disciplines. One such classification by Fraser et al (1997, 1998), gives three academic disciplines of biology, psychology and social sciences but includes the personal and interpersonal knowledge in a general discussion, not as a separate subject area. Becher (1989) describes a typology, adapting the work of Biglan (1973), with four quadrants of a matrix of academic disciplines, which overlap in their boundaries. A limitation of delineating disciplines in this way is to divert attention from the central focus, which is the mother and baby. The matrix, figure 14., offers a representation of propositional knowledge of disciplines, demonstrating the complexities and multiplicity of disciplines informing the science and craft of midwifery. Examples of disciplines that inform the professional knowledge of midwifery are given in each quadrant.

**Figure 14: Typology of academic disciplines informing midwifery professional knowledge**



Typology adapted from Becher (1989) pages 13-16

Two quadrants have pure disciplines: a hard/pure discipline, which has knowledge that is clearly defined, such as, anatomy or physiology; and a soft/pure discipline that is complex and holistic, as in the humanities, where connections can be made between phenomena. Application of the soft/pure disciplines to maternity care recognises the social context of women in the childbearing process.

The two quadrants of applied disciplines add different dimensions. Applied knowledge is concerned with practical application. Hard/applied knowledge, is concerned with activities which have a functional nature such as diagnostic and decision making skills, when the

essence is to integrate theory with practice and make judgements, which are acceptable to women. The soft/applied knowledge draws on a case approach. This knowledge is interpreted according to human experiences in the light of soft/pure knowledge. This type of knowledge is reflected in the current ethos for midwifery care, which adapts care to a woman's choices. There are not firm boundaries between different forms of knowledge (Becher, 1989). Examples of pure and applied disciplines of knowledge are given in table 10.

**Table 10: Examples of pure/applied and hard/soft disciplines of knowledge that inform midwifery**

Pure Disciplines	Applied Disciplines
<b>Hard</b>	
Bio-physiology	Psychiatry
Reproductive Sciences	Obstetrics
Genetics	Gynaecology
Epidemiology	Paediatrics
Pathology	Anaesthetics
Pharmacology	
<b>Soft</b>	
Psychology	Education
Sociology	Health promotion
History	Management and organisation
Philosophy	Communication
Anthropology	Counselling
	Law and regulation

Whilst this classification offers examples of disciplines that inform midwifery, it does not show the complexity of interactions between these knowledge forms.

Midwives' knowledge became more technical (hard/applied knowledge) with increasing use of technological equipment in maternity units, for example, the use of sonicaid for listening to the fetal heart, and the introduction of ultrasound techniques in the 1970s (Tew, 1995). Midwives who assume responsibility for different parts of midwifery care, such as in the antenatal clinic, or the labour suite, become technicians in those specific areas, and are likely to become less sensitive to the full breadth of midwifery practice.

### **Knowledge in Practice**

Mee (1976), during early negotiations for the Midwifery EEC directives, indicated that both objective and interpretive forms of knowledge were requisite for midwifery practice. Mee stated the directives would include:

‘A knowledge of biology, anatomy and physiology in relation to obstetrics and the newborn, and the associated pathology.’

‘A knowledge of the relationships between state of health, and the physical and social environment of the human being and her behaviour.’

(Mee, 1976:152)

Whilst the above are the foundations of knowledges for midwifery practice further subject areas have evolved in this century. The midwife has an increasing repertoire of disciplines that inform her practice table 11.

**Table 11: Subject areas which have been added to the midwifery programme since the 1960s**

Past decade of inclusion	Alterations in the programme and the curriculum, which aided introduction of new subject area	Subject areas introduced at the time of alterations of the programme
1960s	Two part training with a one year training programme to become a midwife	Community health Parent education Anaesthesia Paediatrics Sexually transmitted diseases
1970s	Widened syllabus with introduction of the 1979 18 month training.*	Psychology Social sciences Family planning
1980s	Awareness of accountable health practice within the health service  Development of social theories for caring (includes theories for both the professional and the client)	Legal responsibilities Accountability Ethical issues Health promotion Political issues  Communication Assertiveness Empowerment Autonomy
1990s	Development of care using evidence and research **	(Evidence based practice with research)***
2,000	Applied specialities informing midwifery curriculum diploma and degree programmes	Biosciences Humanities Professional subjects Management and organisation Education

\* (Central Midwives Board, 1979)

\*\*\* not specifically a subject area

\*\* (European Community Advisory Committee on the Training of Midwives, 1991)

Subject areas added are technology development, professionalisation and promotion of rights of a person and awareness of human sensitivity. Table 11. shows the progression of subjects that have been included in midwifery syllabi in the last four decades, in addition to midwifery and neonatology.

### **Personal knowledge**

Each person has her or his own fund of knowledge which is common to others. This is referred to as ordinary knowledge (Lindblom and Cohen, 1979). It embraces not only one's tacit knowledge and one's personal experiences in life but also the method by which knowledge is conveyed to others, such as, how one reacts. This is a knowing of oneself and how one relates to the professional world. The midwife has a self-knowledge in relation to herself and her professional colleagues. Each person has a concept of herself as a professional. The personal knowledge of midwives and teachers, their intuitions, their language and their understandings are conveyed implicitly and explicitly to students.

Personal understandings, based on tacit knowledge and experiential knowledge, are used in decision making. Acquisition of knowledge and experience and integrating them assists in formulating decisions (Benner and Tanner, 1987). This forms a 'personal knowledge' for making intuitive decisions. A midwife's personal understandings emanate from her personal knowledge, experiences and from self-knowledge and reflection.

Skills of reflection are formally recognised skills, which help a midwife to discern her own professional knowledge and theory and to deliberately use these appropriately. The challenge in educating a student is to articulate these processes (Sayer, 1992), which emphasises the importance of the midwife/student relationship. The midwife can assist the student to construct her reflections personally to understand in an insightful way. For example, following assisting a mother and baby with a breast feeding problem, the midwife can draw to the student's attention some of the formal theory she has learnt and relate this to the problem encountered so that the student forms a revised personal understanding of the breast feeding problem.

A form of personal knowledge is interacting with people that might be termed a knowledge of people (Eraut, 1994). This knowledge, acquired mostly throughout experiences of meeting people, is a subconscious acquisition, though it can be selective (Eraut, 1994). Midwifery is concerned with women at a time of their lives when they are most vulnerable. Use of appropriate language and linguistics are important aspects of personal knowledge (Sayer, 1992) in interactions and communication with women.

Communicative knowledge is an area of understanding that is difficult to describe scientifically. Eraut's (1994) explanations of personal knowledge would include social and communicative knowledge, as these emanate from building one's own personal understanding of interactions. This is not only tacit knowledge (Polanyi, 1958) but a



knowledge gained through a social sharing of language, behaviour, and knowledge (Tannen, 1995).

Interpersonal and social skills enable relationships between the midwife, the client and her family. These are an essential use of personal knowledge within professional practice (McCrea and Crute, 1991) and are identified by Fraser et al (1997, 1998) as communication skills in the essential outcome requirements for student midwives. Communication, through verbal, non-verbal and listening skills convey understandings of ways in which humans interact, with an exchange of each individual's tacit understanding (Polanyi, 1958). A personal knowledge of women does not translate into academic descriptions (Oakley, 1993). An understanding of the theoretical and practical dimensions of communication, not only verbal and non-verbal, but also those which differ between cultural and social groups, are part of a midwife's cognitive aptitudes, which convey personal attitudes. Table 12. attempts to summarise the social and communication abilities.

**Table 12: Social and communication abilities of the midwife**

Communication:-
- verbal
- non-verbal
- listening
- writing

Women wish to be involved with their care and make informed choices (Department of Health, 1993). Midwives, through their own understandings and interpretive meanings of social behaviour, interpret women's wishes and thus can be at variance with clients. These interpretations are observed by students, who may tacitly relate these experiences to their own understandings. These social skills, associated with interactions and interpretations of meaning, are acquired by students during observations in clinical practice. The student relies on the midwife practitioner as a role model to interpret and implement theories she has learnt with social and communication abilities.

In conforming to the profession's culture, each midwife develops her individual norms and behaviour from the fund of her personal knowledge. This is a socialisation process in which midwives form their own view of the accepted patterns and behaviour of the women in their care, and they expect women to conform to their views of 'midwifery' (Hunt and Symonds, 1995). Therefore, a midwife through her own personal knowledge and experiences, inscribes women in her care (Fox, 1994) with the expectations that she has of their behaviour patterns.

## **Process knowledge**

Process knowledge is knowing how professional actions take place (Eraut, 1994). This is a 'knowing what to do in procedures'. That is, to know how to act in situations and circumstances in practice. It is deliberative and involves making judgements; making

decisions using analytical skills; utilising a complex actions; and being in control of one's own judgements (Eraut, 1990).

### **Analytical Abilities**

A practising midwife makes decisions, occasionally life saving. Judgements made in clinical practice use experience-based knowledge to form decisions. Judging, as part of the art of practice, relies on the powers of knowing (Polanyi, 1958), including analytical and critical thinking skills. These are complex activities. Knowledge and skills are synthesised to form specific courses of action. Though actions can be sequenced using both theoretical and empirical experience (Eraut, 1990), the process cannot be clearly defined but when applied to situations can form part of skilled behaviour (Eraut, 1994). For example, a midwife who has attempted different forms of relief to reduce a woman's pain may recall a previous use of warm water and try this out again but will, during the course of her action, assess its efficacy and either before, during or after, reflect upon this, with an evaluation. In using her knowledge of pain relief, she will use theoretical knowledge and relate this to her previous experience. Conceptually, she will discern the benefits or the negative points of her previous actions and synthesise this with her knowledge and this current situation. This knowledge, in turn, gives her control over her actions. The actions may not necessarily be slow and deliberate, but may be spontaneous in response to a rapid assessment of a situation (Eraut, 1994).

Decisions made intuitively do not necessarily follow a deliberate thought or action. There may not be a conscious recognition of a formulation of the theory or concepts that a midwife constructs, but a synthesis of professional, personal and process knowledge (Benner, 1984). This is a form of skilled behaviour that Eraut refers to as control knowledge.

Situational knowledge also is being able to recognise a situation and interpret it accurately to take the appropriate course of action (ibid.). Situational knowledge will be present in order that control knowledge can take place. Both situational and control knowledge reside in a midwife's analytical abilities. Table 13. summarises analytical abilities in practice.

**Table 13: Analytical abilities within process knowledge**

<ul style="list-style-type: none"><li>• Decision making</li><li>• Judgements</li><li>• Analysis/ clarification</li><li>• Synthesis</li><li>• Intuition</li><li>• Interpretation of theory in relation to experience\phenomena</li><li>• Discernment of issues in practice + Advocacy</li></ul>
--

## **Skills of advocacy**

Equally relevant to women are the skills of the professional acting as an intermediary between themselves and other professionals such as medical staff. Many midwives see themselves as client advocates (Fraser, 1997, 1998). These skills are particularly relevant when there are conflicts in care, when a midwife can intervene on a woman's behalf and will represent the woman's views to others in the professional team. An instance is that of a woman not being able to receive her choices of care resulting from a practitioner's disagreement with her requests but through intervention by the midwife, a compromise is reached to ameliorate the situation. There are also occasions when women do not understand the implications of care ordered or presented by professionals. The midwife becomes the interceder using her advocacy skills.

Advocacy skills include an awareness of the politics of a situation and the context of care involved. Advocacy is a skill achieved by communication and reaching an understanding, through an ethic of trust between the professional and client (Friedson, 1994). The midwife, as an advocate, must recognise her own boundaries of practice, and the ethics of providing support for her client as she is bound by legal requirements, as well as her personal skills and professional expertise. Knowing the boundaries and acting within those boundaries are part of her process knowledge.

## Organisational knowledge and skills

A further area of process knowledge is organisational skills, that is, how to educate, supervise others and to teach. Though students are prepared for these areas of knowledge, not all are skilled on completion of the course (Fraser et al, 1997, 1998). Whether within the organisation of the health service or working independently, midwives work in groups and require a knowledge of the processes of teamwork and how to co-ordinate others. Knowledge of relationships and dynamics within group organisation has become a necessary part of skills development (Allen, Bourke Dowling and Williams, 1997).

**Table 14: Organisational abilities**

<ul style="list-style-type: none"><li>• Group skills - working within a group as a team member</li><li>• Organisation of self and others in teams</li><li>• Self organisation</li><li>• Leadership skills</li><li>• Management skills</li><li>• Skills to teach others<ul style="list-style-type: none"><li>- students</li><li>- women and families</li><li>- associated workers in health care</li></ul></li><li>• Maintenance of standards and quality</li></ul>
--

In clinical practice the midwife has a responsibility to supervise others, such as support staff and other healthcare workers. In developing her organisational abilities the midwife

identifies with the place of work and her knowledge of the health service. She will have a knowledge of her role within the institution and her area of management, that is of herself and others. This will also include maintaining professional standards of practice. She has a leadership role. Table 14. summarises the above as organisational abilities.

### **Interpersonal knowledge**

A fourth area of the knowledge repertoire of a midwife, relates to her responsiveness or awareness in order to interpret womens' language and behaviour. This has a basis of intuition but requires a sensitivity that is transferred into actions (Oakley, 1993). The sources of women's knowing (Oakley, 1993) offers an added perspective of empathetic understanding and sensitivity to phenomena, that are a key to the art of midwifery practice. Empathetic understanding is recognising the views and meanings of others and responding in an appropriate way to demonstrate sensitivity and understanding. For some aspects of care, midwives and their clients come into very close personal and intimate contact, for example, when a woman is in labour. Intimacy can extend over many hours when certain forms of communication can become of paramount importance to a woman who may be in pain, distressed or under the influence of drugs. There is a human and ethical awareness, which is of a moral nature. Interpersonal knowledge is both insightful and empathetic.

## **Midwifery human and ethical awareness**

The 'caring' in midwifery is sharing with women at a deeply personal time, providing comfort; giving strength and encouragement; being sensitive, creative and flexible: and ensuring that women have confidence in themselves. Care can be equated to forms of sensitivity which 'were part of woman's work' (Dunlop, 1986). Characteristics of this form of sensitivity are concern, compassion and comfort. These constructs are part of the intimate process of care in pregnancy, labour and the puerperium. The words are part of the language used when a woman feels cared for, though the constructs are difficult to measure and quantify but they are the constructs of caring that form part of the language of women. Oakley (1989) argues for a construct of love and that this is a scientific concept, though there is little evidence for the components of this love.

In a qualitative study of 16 members of staff in one maternity unit relationships in midwifery were examined in an attempt to discover whether there were occasions when relationships influence care (McCrea and Crute, 1991). The findings inform us that relationships influence change. Between the midwife and client there may be a 'special relationship,' though what this special relationship is not yet fully understood (McCrea and Crute, 1991; Leap, 2000; Wilkins, 2000).

Midwives and students may have difficulty in articulating the caring role of the profession and rely more on a task orientation which is easier to express. Skills used to promote



information exchange between midwives and clients, which is jargon free, so that the latter can understand, (Leap, 1992) are of an interpersonal nature combined with a 'knowing' of women. Difficulties may occur in communication, in part, because of former dilemmas and conflicts in midwives' personal relationships (McCrea and Crute, 1991; Clarke, 1996b). Caring skills are evident through a midwife's attitude and language and physical approach.

Empathy is of particular importance in times of personal stress such as in loss or bereavement. Empathetic responses are important too, when clients' expectations are not met and there are feelings of personal failure. The sensitive midwife is able to gauge the appropriate emphatic responses in joy or sadness or even in normal interactions. Davis (1985) illustrates the caring components of a midwives' work:

'For if midwifery were practised only as an art and a science then our dilemma and our pain would not be so real, nor would our profession demand such attention and agonising as it does.'

'It is because we have components of our practice that are affective and emotionally based that we are confronted with conflicts and that does not vary anywhere in the world, whether it be Delhi, Dallas, Denpasar?--,or Darwin.'

(Davis, 1985)

The affective and emotional domains are part of the humanness of midwifery and are associated with human interaction of an ethical nature. There are no lasting boundaries in human interaction and problems are addressed in ways that depend upon the circumstances. This suggests that types of knowledge in midwifery are context dependent.

## **Professional responsiveness**

Scientific argument based on either deductive or inductive enquiries may not allow for intuitive qualities in midwifery. Experienced midwives can develop 'hunches'. These are not necessarily based on experiential knowledge but on an intuition that comes also in part from internal feelings. In the clinical situation, midwives can say that they know that something is wrong but cannot explain what. This form of intuition is a sense of knowing from previous experiences and knowledge rather than arising from evidence (Midgley, 1986; Atkinson and Claxton, 2000). There is little evidence of this form of knowledge, except in the discourse between midwives, but previous knowledge and experience can inform such feelings. For example, a midwife in the labour ward at the central station may be heard to say as she leaves the room of a labouring woman: 'I know that something is not right but I cannot put my finger on it'. Such an intuition perhaps arises out of a combination of the traditional craft elements of midwifery, scientific and empirical understanding, prior experiences, former reflections and an ethical orientation.

Midwives also may have a particular empathy with women and some traditional midwives develop their art through a spiritual feeling, or by being in tune with the powers of nature to help them in their knowledge and craft (Vincent, Priya, 1992). The idea that midwifery is transmitted through women with a spiritual feeling is echoed by Gaskin (1990) but is difficult to identify in today's midwifery in the western world. This view of midwifery appears to contrast with the knowledge and skills required by a United Kingdom midwife today, but

alternatively there are elements of women emotionally and empathetically supporting women that are becoming accepted as part of the evolving knowledge of midwifery in today's society. The midwife enters an emotional bond with women to form a relationship (Wilkins, 2000). This requires understandings of responsiveness and a self-awareness of an insightful nature. Table 15. summarises the qualities given above.

**Table 15: Interpersonal knowledge**

- |   |
|---|
| <ul style="list-style-type: none"><li>• Ethical awareness<ul style="list-style-type: none"><li>-Awareness of others</li><li>- Moral and ethical responses in relationships</li><li>- Being empathetic</li></ul></li><li>• Being responsive<ul style="list-style-type: none"><li>- Using appropriate behaviour intuitively</li><li>- Recognise women's self-knowledge</li><li>- Forming relationships with women spontaneously</li><li>- Promote interactions with others</li><li>- Respond to and articulating skills to others</li></ul></li></ul> |
|---|

Learning to be a midwife is acquiring responsiveness to individual women and being empathetic so as to respond appropriately recognising their background and culture.

## **The practice of midwifery**

From the above discussion four types of knowledge inform the practice of midwifery:

- Propositional knowledge
  - Scientific knowledge
  - Professional knowledge
- Personal knowledge
  - Experiential knowledge
  - Tacit knowledge
  - Intuitive knowledge
  - Knowledge of people
  - Uncodified knowledge
- Process Knowledge
  - Procedural knowledge
  - Situational knowledge
  - Control knowledge
- Interpersonal knowledge
  - Human and ethical awareness
  - Responsiveness which is empathetic

Through using this knowledge repertoire within the context of practice, a practical knowledge is formulated of which skills are a part. Combining these knowledges and using them in practice is a form of meta-knowledge. Usher et al (1997) suggest that practical knowledge is performing appropriate actions within a given situation and using a meta-knowledge is complex balance. In using meta-knowledge a midwife balances the use of each form of knowledge and uses them judiciously to each situation to ensure appropriate actions.

Actions are learned through personal experience and by imprinting from other professionals. Skilled social behaviour is combining social skills with knowledge of a practical scenario and acting appropriately. The following examines the knowledges that inform the practice of midwifery.

### **Practical and dextrous skills**

Midwives use all their senses, that is, their auditory, oral, olfactory, visual and tactile senses. In turn, these connect with dextrous skills that are essential elements of a midwife's vocabulary. Skills that incorporate the senses are learned through apprenticeship, through trial and error; through discussion; through verbal intimations and non-verbal interactions with other midwives. This use of the senses is not only using skills but an interpretation of the appropriate knowledges attuned to the senses, that forms the craft of midwifery.

Midwifery units had, until the 1980s, detailed procedures for tasks undertaken in practice that dictated which hand should be used for each part of the task to be undertaken. Prior to this tasks were laid down through guidance from the matron of the maternity unit or the head of the midwifery services (Greenwood, 1995). Student midwives not following the detailed guidelines were appraised of their misdemeanours. The standards were prescriptive and there was little provision for variation. The skills were passed from professional to student. In the community, these skills were likely to be passed on verbally and in demonstration. In the

hospital, knowledge was based on routines, as shown by instructions for Nottingham midwives (Allison, 1996). These routines were agreed by obstetricians and midwife managers.

In the past, patterns of care and the midwifery syllabus were prescribed by the midwives' rules (Great Britain, 1951). Patterns of care could be equated to the task organisation of a factory production line, with each task forming part of care being completed independently (Thomson, 1980). An example is taking a woman's temperature postnatally. Guidance was given as to the number of times, when this was to be taken and the levels at which medical aid must be sought. A task approach, split into its component parts, was part of the analysis of work described by Taylor as scientific management (Pugh, Hickson and Hinings, 1984). This form of piecework became accepted practice within organisations within post-war society, and provided a structure for skills to be passed from practitioner to student. Emphasis now, is on processes of care with flexible guidelines so as to provide an individual approach (Department of Health, 1993).

Using knowledge appropriately requires a creative element (Maxwell, 1984). Some skills with relevant knowledge are repeated in the clinical care of each and every woman, for example, the way in which a midwife examines a pregnant abdomen. Students are not always able to consolidate the knowledge of these skills by the end of their course, in particular, the more complex skills such as catheterisation or applying a fetal scalp electrode (Fraser et al 1997, 1998). These skills will be adapted to individual situations, but using complex forms

of knowledge in so doing. It is adaptation and flexibility to each situation that is a creative element of midwifery 'artistry' (Schon, 1991b). Responding to individual situations cannot be learnt theoretically.

### **Characteristics of midwifery**

The skills and knowledge required to practise as a midwife can be detected from an analysis of the World Health Organisation definition of a midwife, The Activities of a Midwife Article 4 of the EEC Directives and the United Kingdom midwives rules (World Health Organization, 1992; European Economic Community 1983; UKCC, 1998b). As it is difficult to draw a line between what is a skill and what is knowledge, as in practice they interact and interrelate, the combination of these is referred to as abilities. The components of midwifery are extracted from the above documents and shown in lists in the following tables 16. and 17. The tables indicate requisite skills and examples of knowledge within the documents. Examples of knowledge given in the right hand columns relate collectively to the skills in the left-hand columns. In practice knowledge informs skills and the skills form part of knowledge. Both combine with cognitive, behavioural and attitudinal forms of knowledge. Midwives interpret their approach to midwifery through their education, the professional traditions and the cultures of their countries of origin.

**Table 16: Components that characterise midwifery practice  
incorporating the WHO definition of a midwife, and  
the Midwife's Directive 80/155/EEC**

<b>Skills</b>	<b>Examples of Knowledge</b>
<ul style="list-style-type: none"> <li>• Supervising</li> <li>• Giving care and advice</li> <li>• Conducting deliveries</li> <li>• Monitoring care</li> <li>• Diagnosing</li> <li>• Prescribing</li> <li>• Recognise warning signs</li> <li>• Examining</li> <li>• Educating</li> <li>• (Taking) Preventive measures</li> <li>• Counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Antenatal education and parenthood</li> <li>• Pregnancy</li> <li>• Intranatal and labour</li> <li>• Post partum period</li> <li>• New born and Infant</li> <li>• Abnormal conditions of mother and child</li> <li>• Gynaecological disorders associated with pregnancy</li> <li>• Family education</li> <li>• Family planning</li> <li>• Health counselling</li> <li>• Childcare</li> </ul>

If one adds to the above lists of knowledge areas and skills which are defined within the midwives rules (UKCC, 1998b) table 17., midwifery practice encompasses an even wider scope.



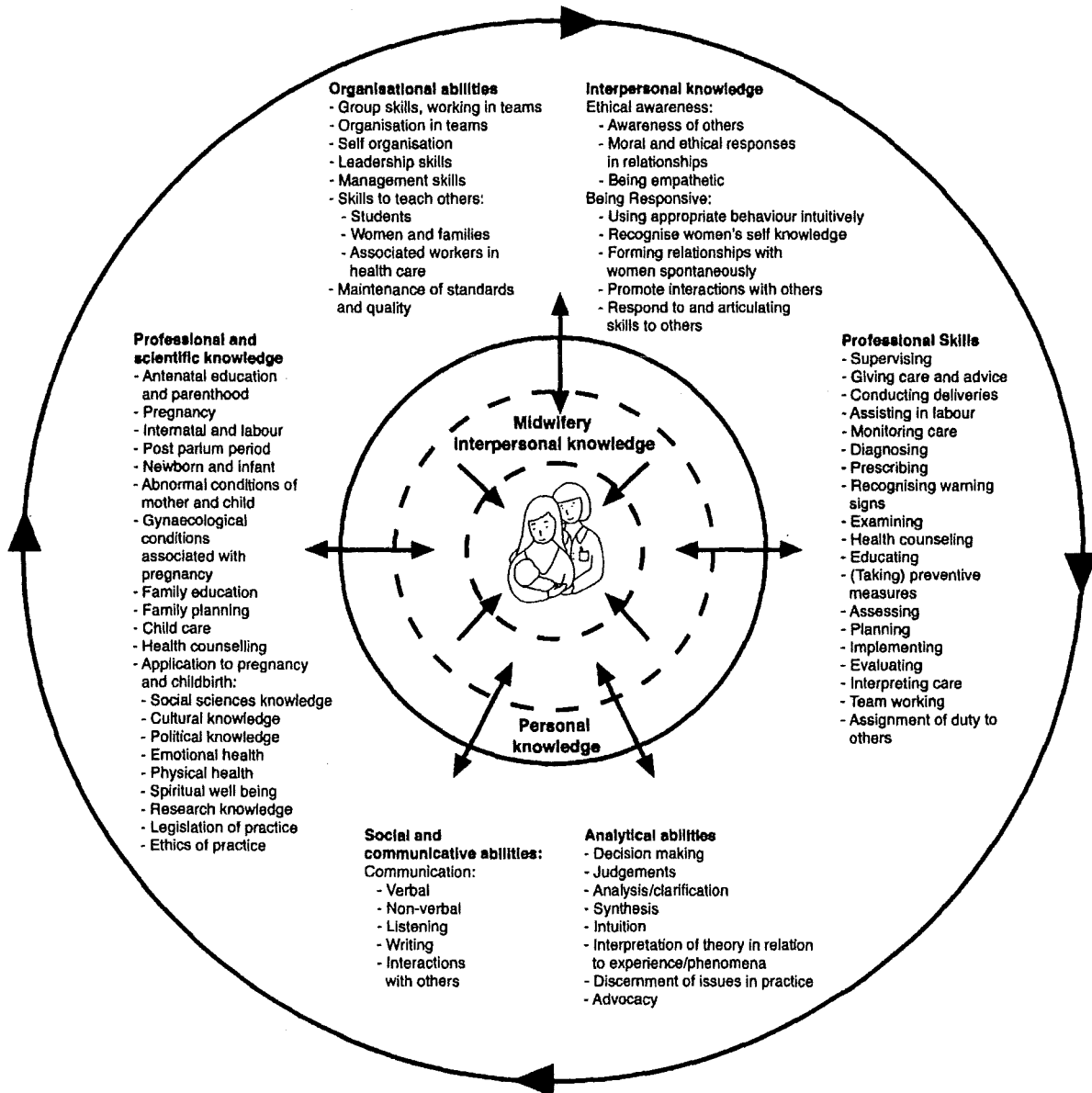
**Table 17: Components of a midwife's practice  
incorporating UKCC midwives rule 33.3.C i-xi**

Skills	Examples of knowledge applied to pregnancy and childbirth
<ul style="list-style-type: none"> <li>• Assessing</li> <li>• Planning</li> <li>• Implementing</li> <li>• Evaluating</li> <li>• Interpreting care</li> <li>• Communication skills</li> <li>• Team work</li> <li>• Assignment of duties to others</li> </ul>	<ul style="list-style-type: none"> <li>• Social science knowledge</li> <li>• Cultural knowledge</li> <li>• Political knowledge</li> <li>• Emotional health</li> <li>• Physical health</li> <li>• Spiritual wellbeing</li> <li>• Research knowledge</li> <li>• Legislation of practice</li> <li>• Ethical knowledge of practice</li> </ul>

As these forms of knowledge are used in practice they become part of skills and formulate a practical knowledge.

A map of midwifery knowledge, in figure 15. (next page) demonstrates the intricate webbing of the matrix formed from scientific knowledge, social sciences, interpersonal and social skills, organisational abilities and manual dexterity. These are combined in propositional and process knowledge. Surrounding the matrix are two inner rings, which interact with the outer matrix.

**Figure 15: Map of midwifery knowledge**



One ring is the personal knowledge of the midwife, with her own fund of individual and tacit knowledge. The innermost ring is of midwifery interpersonal knowledge including personal awareness and intuition characteristics of women's insight.

## Conclusion

Central to new knowledge for a profession is the practice upon which it is based. Individuals can only develop knowledge of their society through interaction with that society (Sayer, 1992), which suggests that professionals should know the context and the environment of their practice. Academics and practitioners therefore, must stay alive to each other's knowledge. The chapter has not sought to illuminate the wider issues of knowledge that determine competence as outlined by Fraser et al (1997, 1998) nor attempted to delineated forms of knowledge that determine capability. It has illuminated forms of knowledge that a student gains in her relationships with professionals in learning practice.

Within students' learning, each will develop their own particular repertoire of knowledge, which is formed from propositional, personal and process and midwifery interpersonal knowledge. Different forms of knowledge crisscross each other (Phillips, 1987) in complex interrelationships forming a meta knowledge. Midwifery interpersonal knowledge is derived from midwives responding to individual clients. Intuition and decision-making are derived from reflection and analysis, emanating from each individual's sources of knowledge. But knowledge within the profession relates to the knowledges of society and societal expectations. An epistemology for the profession is needed; linking both philosophies of positivistic and interpretive paradigms could generate wisdom (Maxwell, 1984).

The central point for all decisions in midwifery is the mother and child. It is from the intertwining of both the empirical and scientific components with skills that a personal understanding that enables a midwife to apply her craft in caring for women in childbirth. Knowledge leads to understanding and understanding to wisdom. Practice knowledge is a formulation of the four domains of knowledge and using these in professional settings. The is the essence of learning to be a professional. Therefore, identifying the forms of relationships and influences upon these that aid students in combining and understanding these knowledges in practice is important. Combining the art and science creates the 'wise woman' of today. In developing this craft the students is influenced by the overt and covert curriculum. It is to this subject that the discussion now turns.

## **5 Students' Learning and the Curriculum**

### **Introduction**

The purpose of this chapter is to examine the multiple contexts of student learning. An exploration is made of specific curriculum issues, especially the roles of those involved in preparation of students pertaining to relationships. Teachers and practitioners are referred to generically as educators. The importance of student learning, highlighted by the Dearing Report (Great Britain, 1997b), is to guide students to be effective learners, to manage their own learning and to equip them to be life-long learners. Students in a higher education programme should acquire analytical and communication skills so being able to discuss and debate within their speciality (ibid.). Equally relevant in their education is their ability to practise with competence.

The learning sites for midwifery are in two different public sector organisations, that is the health services and higher education. Both sectors have their own distinctive social milieu and learning environments. On the one hand a university education provides a student with a balanced system of education, namely 'instruction in skills', of which knowledge must be a part; promotion of the 'powers of the mind'; 'advancement of learning'; and 'transmission of a culture of citizenship' (Great Britain [Robbins Report], 1963). On the other hand the Health Service of the future will 'offer people prompt high quality treatment... improve health and reduce health inequalities... It will work in partnership with others... and give emphasis to the role of nurses' (Great Britain, 1997a). Preparing students in these public sectors with their different goals requires a curriculum approach that marries the requirements

of each and which grounds a student with skills to equip her for future learning within a changing health service (Great Britain, 1997a).

### **Student experiences of learning**

The practice arena builds a student's experiences through her assimilation of multiple episodes of different events that adds new aspects to her repertoire each time situations are encountered. It is the student, herself, who brings together the knowledges acquired from formal educational delivery and from the clinical situation, into her understandings. She balances her comprehension of both the public and hidden curriculum. (For example, when she relates the theory of pain relief to the different exhibitions of pain, presented by women.) Her interpretations (plural because the student may have several thoughts and/or theories about different types of pain at the time) of a woman's pain and appropriate forms of pain relief will be formulated from theories derived from the education institution and theories-in-practice. But, the student learns also from perceptions of actions, explanations, attitudes and responses of both practitioners and clients in their relationships. This learning will be assimilated with her previous experiences to build a stock of knowledge and skills.

Midwifery, as a human activity, draws from disciplines such as sociology, physiology and environmental studies. Students use theories from these disciplines in their practice. This requires skills and knowledge to integrate specialist understandings from midwifery and other disciplines with personal knowledge. One dynamic in this process is the role of the teacher and/or the practitioner in facilitating learning (Rogers, 1983), a second is the role of the mother and the baby.

A written curriculum presents the overt practices within educational programmes that may not expose the reality of the covert influences on student learning such as the effects of relationships (Illich, 1971). A curriculum is a structure of the learning experiences within a course programme. The overt curriculum is planned, documented and open to public scrutiny. A covert curriculum is the hidden experience received by the student whilst undertaking the course programme. Curriculum statements offer an insight into midwifery education. A written curriculum does not always reflect actual learning or its context or relationships. At most, it provides a frame for an emergent student experience.

Content analysis of curriculum documents, accordingly, offered an insight into the context of learning relationships, and the roles taken by the academic, the practitioner and the student. The analysis, in appendix 2, used documents for 8 diploma and 4 degree programmes to develop the theory for this chapter. Six were 18 months programmes and 6 were 3 year programmes in both the 'old' universities and the 'new' universities - the former polytechnics (Department of Education and Science, 1991). Similarities were apparent with the analysis completed by Fraser et al (1997, 1998) in that the curriculum documents used a serialist approach, moving from a state of health to illness, though, as Fraser et al suggest this does not reflect the students' experience in practice. Only one document demonstrated a more holistic approach with use of clinical experience to demonstrate integration of formal theory with practice. This curriculum document analysis did not analyse the content or learning strategies per se but sought to illuminate processes concerned with relationships in learning.

A student's professional development is framed by the legal requirements which are designed to meet competencies for practice (UKCC, 1998b) and as indicated by Fraser et al (1997,

1998). Criteria, with standards in relation to learning and teaching strategies and practical experience, are stated by the English National Board (English National Board, 1994b). The time limits for educational programmes set by the English National Board for the student to spend in theoretical instruction and clinical practice, are interpreted independently by each institution (*ibid.*) though Fraser et al note that more theoretical time is allocated initially in the non nurse education programme.

Teaching and learning within the academy are not always the epicentre of a student midwife's learning experiences, given that the focus is on the health of mother and baby. The geographical separation of the educational institution and practice areas can vary from under one mile to over 50 miles. This creates a time and space divide for teachers, practitioners and students, which sets challenges in bridging university and health service education. Class sizes can range from ten to fifty or more, with different structures for administration, group sizes and student support.

### **The context of learning**

The context of learning is presented through written curriculum documents, though may not encapsulate all the different aspects of a student's learning experience. Ideally a curriculum for midwifery encompasses the total experiences that a student encounters to learn to be competent to practice. As in Fraser et al's (1997, 1998) analysis, there were similarities in the construction of documents but differences in the quality of presentation, particularly notions of learning in practice, with emphasis on formal instruction in the education setting.



## **Curriculum organisation**

Curriculum theory for midwifery instruction requires prescribed elements, such as competencies and elements of discovery in learning experiences (Bruner, 1966). A curriculum offers a representation and guide for achieving standards. There has been a shift of curriculum models from the technical biomedical models using a product approach (Tyler, 1973) to models based upon a process approach (Bruner, 1977; Stenhouse, 1986).

An examination of curriculum documents demonstrated distinctive frameworks used for curriculum planning (appendix 2.). All curriculum documents referred to the competencies in the midwives rules and code of practice (UKCC, 1998b). Firstly, all documents indicated use of a product model, with outcomes using educational objectives or goals with summative outcomes (Bloom, 1956; Bloom, Krawthohl and Masia, 1964; Simpson, 1966; Tyler, 1973) that Fraser et al (1997, 1998) refer to as a technical-rational model. A product model with behavioural objectives restricts a curricula approach and Fraser et al warn of the dominance of this approach. However incorporating a product approach is appropriate in a midwifery curriculum because of the legal and professional requirements necessary to meet specified outcomes though behavioural objectives are limited to observable behaviour (Hirst, 1975).

A second curricula framework used was a process model, using a spiral form of curriculum with connections between units (Bruner, 1977). This is a curriculum with a re-introduction of learning themes which are built upon progressively throughout the programme. Sutcliffe (1992) suggests that the latter approach is a suitable mode for induction to a profession and argues that this approach will reduce the theory/practice gap. The process model encompasses learning skills of self-direction and reflection. A process of reflection (Stenhouse, 1986)

within a framework of revisiting knowledge and experiences assists students in their understanding of practice and enables them to consolidate experiences before moving onto new theories and applying these to practice. The advantages of this model are not highlighted by Fraser et al (1997, 1998) and they promote a curriculum that questions and uses a problem design approach. Stenhouse (1986) further discusses the success of the process model of the curriculum being dependent upon the quality of the teacher. There are similarities here with a problem design approach.

A third curriculum design used was a framework which reflects the situation in which a student learns (Lawton, 1978). The experiences that a student will encounter in practice are selected from the professional learning situation. The learning programme is organised in structured sequences of learning (ibid.) and could be incorporated into a problem design approach.

A model for midwifery ideally includes elements from the three models that promotes reflection and questioning. There is complexity in combining a technical rational model with a curriculum that promotes thinking and freedom of choice in education rather than selecting specific content (Fraser et al 1997, 1998). Midwifery is primarily women centred, and practice and education should have an equal influence, thus recognising the culture of care (Evans, 1984; Sutcliffe, 1992). A process approach requires an emphasis towards learning that emerges from issues in clinical practice but the essential feature of a midwife is her safety in practice, so an objectives model stating goals to be achieved to a stated level of competence can also be incorporated.

## **Culture of learning**

The delivery of education between higher education and health sectors offers a student experience in varied cultural locations associated with educators who have different priorities (Hewison and Wildman, 1996). This, therefore, demands a partnership of co-operation between teachers and practitioners with participation of staff at different levels of the organisations. Maintaining a dialogue at different levels will ameliorate a divergence of views. The culture of the learning environment is partly dependent upon implicit strategies and theories used within a curriculum.

Midwifery engages with the personal lives of students when encountering human and emotional events. Students who are engaged individually in their learning experience reflect and can be helped to focus on their 'lived experiences' (Schon, 1991a). Personal and confidential information is more likely to be shared when students have confidence in the environment of learning (Stockard and Mayberry, 1992).

Midwifery education has evolved with a strong vocational element. Its roots are in practice, but the move to higher education has brought the benefits of educating a student to be articulate and reflexive. A disadvantage is a separation of formal education from the centre of practice. It is therefore crucial to create links to provide and activate dialogue between the two sectors. This requires flexibility on the part of the institutions.

Students learn the practice of midwifery from being within the health service and therefore their communication and associations with practitioners are a crucial part of their learning. Although each student is influenced by her own personal learning experience, the focus is on

the client. Learning within situations surrounding the client is a dominant feature in acquiring practice knowledge (Ogier, 1989). The environment for practice-based learning and richness of experience in the clinical area enables students to develop the art of their practice (ibid.). The environment in which the student acquires the practice of midwifery is also where a student encounters a covert curriculum (Stenhouse, 1986), that may bring both positive and negative experiences.

## **Becoming fit for practice**

### **Developing competence**

In becoming fit for practice the student learns to be competent in the requisite skills. The term competence used here is the ability of the student to achieve mastery in areas of practice. This requires acquisition of both operational and academic knowledge and skills for the appropriate skills (Barnett, 1994).

Learning is not confined to experiences in higher education or midwifery practice only. It can occur in and out of work. It is through relationships and dialogue with colleagues, and other professionals in academia or practice that important cues encourage learning. The student learns and develops knowledge, theories and concepts and uses these in practical situations through perceptual development (Benner, 1984). Benner considers that perceptual recognition occurs through descriptive and interpretative recording, and by comparing and evaluating experiences and exchanging judgements. Both teachers and practitioners, in evaluating experiences with students, reflect upon their practice, and develop new meanings

(ibid.). This is an active process in which the student is engaged when faced with discussions and judgements in practice. Each meeting with a mother and baby offers a potential new context, and is a situation upon which the student can reflect and develop revised constructs and meanings. The meaning will depend upon the theoretical and empirical knowledge already gained and previous experiences.

Mastery of a field of knowledge and skills is not only accomplished by demonstrating authority in a specialist way (Pearson, 1994) but through an ability to use knowledge associated with skills appropriate to a situation and evaluate this critically. Creativity can be used in decision-making in different situations (Eraut and Cole, 1993). The educator can guide and encourage a student in this process through personal and professional interactions. Students must learn about normal childbirth and, when deviations occur, recognise their role and responsibilities. Explaining the differences and creating a dialogue with the student to show how theory informs practice gives a confidence necessary to gain competence. There is complexity in understanding definitions of competence in midwifery (Worth-Butler et al, 1995). Standardisation at different stages in the programme could limit an individual's progress. The interactions between educators and students are relevant in clarifying an individual level of performance. This necessitates the educators to share ideas of the curriculum and practice.

A student's competence is evaluated through assessment and Fraser et al (1996) argue that competence for assessment should be viewed from a consumer perspective. It is noteworthy that in nursing Benner (1984) offers 'competence' as a mid-point in an expert nurse's development as she considers that expert nurses become proficient. Competency statements

usually embody a minimum level of performance (Worth-Butler, Fraser and Murphy, 1996; 1995) that may be viewed differently from a consumer perspective.

Assessment of competence is an ethical activity, accountability residing with the assessors (Milligan, 1996). These are the lecturers and the practitioners. As competency assessments are prone to subjectivity of an individual's perception of levels of performance (While, 1994) it is appropriate that all assessors fully understand their role, the purpose and meaning of competency statements.

### **Learning through experience**

All situations, whether in the academy or in practice, can be a potential learning experience through the concept of experiential learning, which utilises a triad of personal experience, reflection and transformation of knowledge with new meanings (Burnard, 1986). Benner's (1984) framework gives five stages of professional development, through which a practitioner moves from novice to expert. This offers insight into the progressive stages through which a person assimilates learning experiences. The stages, based on a skills acquisition model (Dreyfus, Dreyfus and Athanasiou, 1986), move from 'novice', 'advanced beginner', 'competent', 'proficient' to 'expert'. Benner states that some nurses reach the level of 'expert' after five or more years, though others remain at the level of 'proficient'. Benner applies this taxonomy to experienced practitioners, as did Dreyfus et al (1986) to experienced pilots.

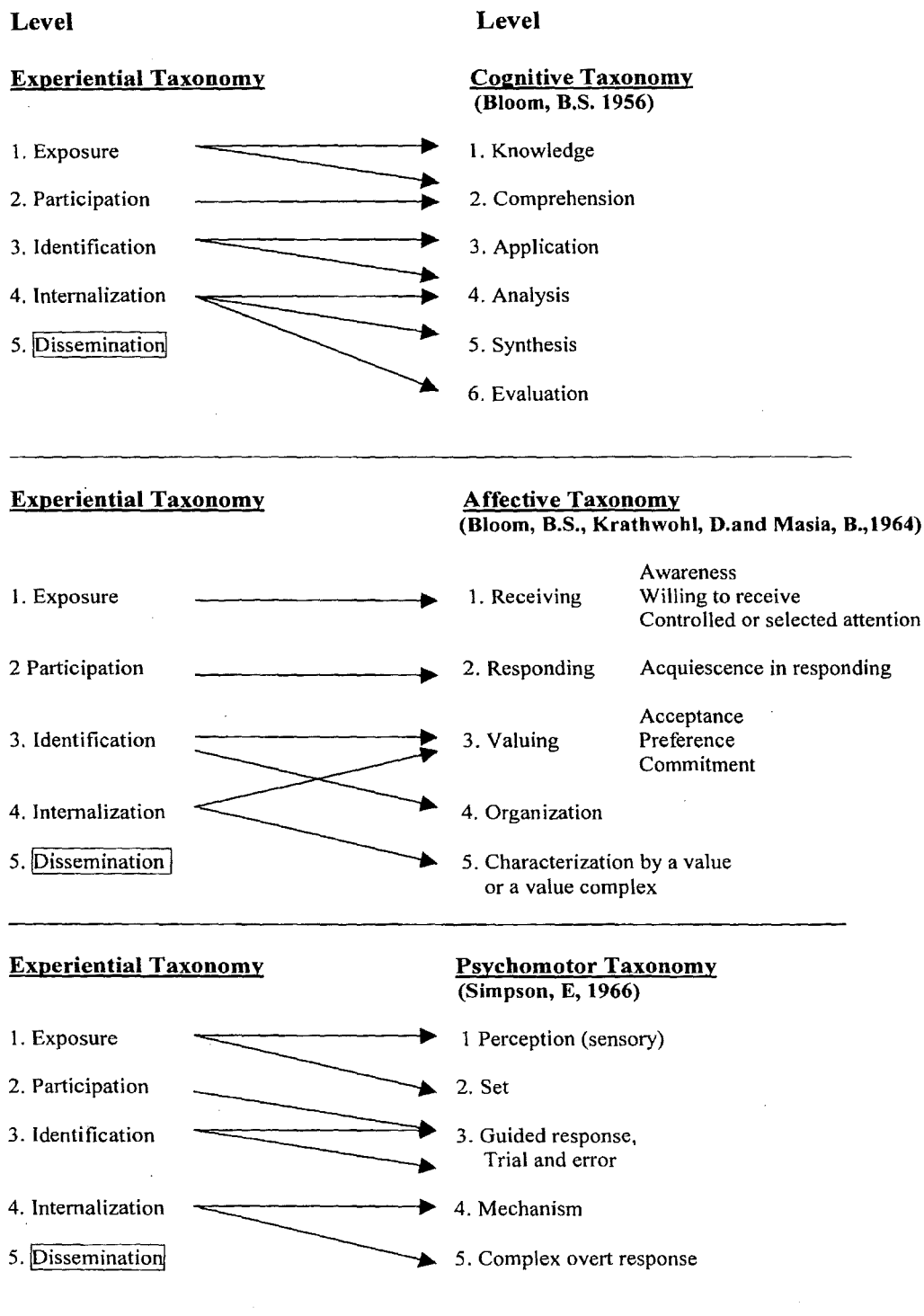
When this taxonomy is applied to a curriculum for an initial education programme, the schema of development is limited in that only three stages, 'novice', 'advanced beginner' and finally 'competent' can be achieved in the training period. It does not explain the detailed experiential progression through which a student learns, from a state of unknowingness to that of a skilled knowledgeable practitioner. Acquisition of knowledge and skills in a training period, that has a limited time span, are better understood through a taxonomy which breaks learning into progressive stages. In learning different tasks at varied levels, students develop their own personal library of experiences. Upon these they build further practical knowledge, to develop the intuitive skills that are formed from making decisions in action (ibid.).

Kenworthy and Nicklin (1986) use an experiential taxonomy of learning with five levels (Figure 16.). They integrate these through adapting Steinaker and Bell's (1979) taxonomy based on the a) cognitive, b) affective and c) psychomotor domains in taxonomies of Bloom (1956), Bloom, Krathwohl and Masia (1964) and Simpson (1966). In figure 16. the five levels of:

1. Exposure;
2. Participation;
3. Identification;
4. Internalization and
5. Dissemination'

are related to stages of each of the three taxonomies of the above authors: that is, in the a) cognitive, b) affective and c) psychomotor domains.

**Figure 16. Experiential Taxonomy of Learning in Practice: A comparison of other taxonomies with the experiential taxonomy**



(Modified from Kenworthy and Nicklin, 1986)



Kenworthy and Nicklin's (1986) argument for the experiential taxonomy lies in the vocational nature of nursing, where the three domains: cognitive, affective and psychomotor cannot be separated. This is similar in midwifery. The first level in the experiential taxonomy of 'exposure' is when a student first meets a specific situation that provides the context for learning. This can be in practice or experientially in the classroom or laboratory. The second level, 'participation', is when a student learns the individual knowledge and skills of the three domains and is involved in the process. The knowledge and skills may need to be acquired individually and repeated on several occasions for integration.

The third level of 'identification' is when students revisit experiences, which aid them in clarifying the experience emotionally and intellectually. Students build on this level as tasks become more complex. The fourth level is a process of 'internalization' when students gain confidence in the simpler tasks that they undertake. The fifth and final level in the process of learning is 'dissemination'. Achievement of the fifth level of 'dissemination' is when the skills of a task are formulated into a whole and the student is able to disseminate information (Kenworthy and Nicklin, 1989). These two taxonomies of Benner (1984) and Kenworthy and Nicklin (1989) predominate nursing curriculum documents (Gerrish, 1997).

### **Transferring knowledge and skills**

Gagne (1977) shows that concepts, once learnt, can be applied to other situations. Transference of cognitive elements is increased through problem solving activities and these are recommended by Fraser et al (1997, 1998). Transference of learning includes cognitive, psychomotor and affective elements. For example a nurse entering midwifery knows the knowledge and skills to take a blood pressure recording, but to adapt this to midwifery will

require further specific information to detect pregnancy deviations. This entails not only details of the skill (psychomotor domain) but also specific physiological knowledge of pregnancy (cognitive domain) and also the appropriate empathetic responses so as not to induce anxiety in a woman (affective domain). These activities may require the facilitation of an educator to aid transition. Transferring learning from one situation to another requires each experience to be meaningful (Alexander, 1983). To promote transferability, the relevance and meaning of knowledge domains must be fully understood to transfer them to midwifery. The transfer can be positive or negative. A knowledgeable educator can influence students in developing skills to transfer their conceptualisation of previous domains of knowledge to new issues.

As a coping strategy within the new environment of midwifery, those who have been nurses may temporarily revert to a student status of doing routine tasks such as returning to do observations or continuing with trusted nursing duties, in contrast to taking on new skills as a student midwife (Davies, 1990). On becoming a student midwife, there is a major shift in social status, which causes a student to take on the role of studentship. In returning to familiar tasks she fails to transfer previous experience (Davies and Atkinson, 1991). The educator can circumvent this process by recognising a student's previous knowledge and skills and seek to extend these. Aiding the process of transference from previous knowledge and skills for the non nurse student is particularly relevant in their relationship with their educators.

The student may have grasped the basic knowledge and skills of taking information from women in a given situation, such as routine history taking, though when confronted with a

minor problem, may need guidance and direction from the clinician to achieve confidence in the extended task. In this way, a student builds a vocabulary of new skills that she can transfer to other situations. The supporting midwife's role can be positive in reinforcing the process, or negative which inhibits the building of new understandings.

### **Learning through reflection**

The teacher and clinician have complementary functions in assisting students to develop their role in practice. They both have a role in their different settings in stimulating threefold processes for students to use knowledge in practice with forms of reflection:

- reflection-before-action (Greenwood, 1993)
- reflection-in-action (Schon, 1991a)
- reflection-upon-action (Schon, 1991b)

These processes will promote students' ability to form their own personal and professional knowledges and enable them to recognise their tacit knowledge (Polanyi, 1958).

Jarvis (1984) considers that a foundation of theory and practice is central to the process of reflection. The teacher or practitioner can provide a student with the rudiments of knowledge prior to undertaking new experiences that complements a student's personal knowledge and provide the basis for reflection. Reflection, as an active process, can take place through reviewing incidents and student self-review of actions (Brookfield, 1987). Undertaking reflection and using incidents requires a personal commitment. This type of reflection is an

important human activity, in which knowledge and experience are recaptured and processed to provide a new construct (Boud, Keogh and Walker, 1985). The educator can actively promote a discussion of incidents which provides students with the opportunity to reflect and rethink learning experiences.

Skilled practitioners may repeatedly restructure situations with students verbally and use diagrams, dummy models and arm gesticulation, to illustrate a preceding practical skill. Whilst reliving experiences, learning by reflection is assisted by a role model, who clarifies meanings that relates theories to the practice. Through verbal and non-verbal communication between student and practitioner the situation is relived and repeated in different dimensions.

An educator can aid the process of reflection by assisting the student to evaluate their ideas and attitudes (Burnard, 1986). Rogers (1983) advocates this role for the growth of both educator and student, which is brought about through communication in a relationship. This can personalise learning for the student. There are risks for the educator in having uncertainties, such as excessive student demands, or not being able to comply with the student's wishes (Kenworthy and Nicklin, 1989). However uncertainty and ambiguity can stimulate learning.

## **Roles in the learning process**

### **The student as learner**

The learner has two roles, one as an academic learner, the other a learner in clinical practice. Being a learner in clinical practice is of a vocational nature, that includes professional practice with advanced skills of intuition and decision-making (Benner and Tanner, 1987). Both roles have to be balanced. The student is required to be self-directed, that is to know her own goals and how to achieve them, though she may need assistance in this process (Knowles, 1975). As most midwifery students are mature learners, they should demonstrate the following characteristics: willingness to learn, motivation, self-directedness and enthusiasm which are characteristics identified for adult learning (Knowles, 1990; 1988; 1984). This approach to learning was evident in Fraser et al's (1997, 1998) analysis, however there are times when a pedagogic approach is appropriate in learning.

As the educational programme progresses students differ in their motivation. Students are influenced by their environment, their clients, their relationships with their facilitator/mentor (Alexander, 1983), and their teacher. Motivation is dependent upon learning skills that are a) appropriate to the different levels of learning in the experiential taxonomy and b) a student's self interest in learning. Being able to move from one level to the next and achieving confidence in one area before moving to the next requires guidance (Rowntree, 1987). Students are motivated to learn when confronted with clinical or theoretical problems or if challenged to learn through using problem solving skills (Rogers, 1983). A midwifery

student faces a problem with each encounter with a client. This poses a challenge for her, but it will only be appropriate if she has the level of theoretical and experiential knowledge that she can transfer to the situation.

To understand the ideals of student-centred learning and have control of self-learning requires a sense of self-responsibility (Sweeney, 1986). To have personal power for their learning (Brown, 1993), students require recognition as individuals. Students require skills of negotiation and enthusiasm to inspire others to help their learning, as it is through use of interpersonal skills with humaneness, empathy and sensitivity to others that they can gain from others. Mature students have life experiences and events, which can cause stress, and they need special support (Wood, 1992). This is particularly relevant in midwifery, as many students are women. Debriefing is necessary as a form of learning both initially and prior to reinforcement of learning (Hart and Rotem, 1994). When working in partnership with lecturers and clinicians, students require equal recognition for themselves as people, though not necessarily academically and clinically, to take responsibility for their own learning goals. In developing this responsibility, they need to show initiative making their own requirements known (ibid.).

Learning what is acceptable and what is not acceptable can be contrasted to rewards and punishments in learning (Gagne, 1977). In relationships between midwife and student, positive and negative signs will indicate appropriate behaviour. The student gains mastery of her learning in a progressive manner through being set tasks and accomplishing a complex sets of skills. The source of tasks must be a master, that is, an educator, who is proficient and provides an example (Davies, 1971).

In the education programme, during experiences gained, students move from being an outsider of the profession to being an insider through socialisation. From experiences, they learn their professional attitudes and behaviour. Changes in experience, such as allocation to clinical areas and new settings can reduce self-image and identity, thus students may turn to tried and tested routines to overcome the difficulties of newness (Davies and Atkinson, 1991). Their confidence in themselves may also depend upon their opportunity to practise, to make sense of their experiences and use the knowledge that they have gained (Alexander, 1983). They need skills to develop active forms of reflection to make sense of theory (Schon, 1991a).

### Apprenticeship

The relationship of a professional student to the practitioner is one of apprenticeship (Alexander, 1983; Day et al, 1998). In this association, the student learns how to behave, how to ask, and develop her practice on role models (ibid.). Schon (1991a) describes learning through apprenticeship in architecture to become reflective as a practitioner. It is through the relationship between master and student, that students learn 'the practicum', that is learning through tasks in a 'practice world', that falls short of the 'real world' (Schon, 1991a:36-37). Learning a human, emotional and practical profession through apprenticeship is in the 'real world'.

A master and student relationship is one of joint experimentation when the student tries out different ways to complete tasks whilst being assessed. This is possible when tasks are broken into manageable parts and when there are clear objectives (ibid.).

## Role of the practitioner in student learning

The midwife in the clinical setting has a role in the education of students and acts as a role model (Myrick and Barrett, 1994; Fraser et al, 1997, 1998). Furthermore, it is through this relationship that the student's awareness of her role and responsibility to women is raised. Various terms have been used to describe the role. Each of the stated roles has a distinctive function in relation to the student, though the definitions overlap. The roles described below (table 18.) combine to form the 'ideal' role of a practitioner in assisting a student in learning.

**Table 18: Terms applied by different authors to the clinician who has responsibility for educating students in practice:**

• Mentor
• Coach
• Facilitator*
• Supervisor*
• Assessor*

\* These roles are also ascribed to teachers

Though the term mentor is commonly used for the role of the clinician, perceptions of this role may differ between student and the clinician (Anderson et al., 1988; Myrick and Barrett, 1994).

The clinician has an invaluable role in supporting students in relating theory to practice (Newton and Smith, 1998), and through this relationship effective learning can be promoted (Marrow and Tatum, 1994). It appears that qualities of respect and trust are necessary in all



the different roles (Morton-Cooper and Palmer, 1993; Day et al, 1998). Furthermore, consistency of a person undertaking this role in the clinical setting is one that promotes confidence in learning (Myrick and Barrett, 1994). The nature of the relationship between the clinician and the student is one that influences learning.

### Mentor

This term is used to describe a person who supports, advises, guides, counsels and is a helper (Clutterbuck, 1985). The qualities of a mentor fall into three areas, organisational skills, communication skills, and midwifery skills (Morton-Cooper and Palmer, 1993).

Mentorship is demonstrated by a mutual understanding and a degree of intimacy that is reflected in dynamic relationships (ibid.). Personal understandings can occur between practitioners and students where there is little age difference or there are mutual social interests or other circumstances that bring the two people together for situations outside the teaching mode. Where a student and midwife are working in a close partnership, such as within a team or one to one, this mutual relationship could be possible. A trainee or student may choose a mentor where the process is not formalised (Clutterbuck, 1985) but that person may not be the one allocated for facilitating learning, or designated to assess the student's practice (Morton-Cooper and Palmer, 1993). In midwifery the mentor role is formal with an identified named mentor who has defined responsibilities and is accountable for student learning. The role of the mentor overlaps with a coaching role described below.

### Coach

Schon (1991a) describes the coach role as one that progresses in its dialogue and communication, initially from a lack of understanding between coach and student, with possibly a gap of experience and knowledge, to one of achieving a shorthand of words and gestures in mutual recognition, through dialogue and communication. This process takes place through practical situations, using actions and words and through mutual reflection-in-action stimulated by the coach (ibid.). The coach role is a pedagogic role with the student in a personal relationship with the educator (Jarvis, 1995). The 'coach' is described by Schon as one 'whose main activities are demonstrating, advising, questioning and criticizing' (Schon, 1991a: 38). It is also a 'follow me style' which is one where the master advocates 'one right interpretation' (Schon, 1991a: 38). This may not be appropriate in midwifery when situations may require different responses, for example when interacting with women in a counselling role the response may require individual interpretations. But the 'follow me' style is appropriate where the student is expected to learn life saving skills, such as stemming haemorrhage. The responsibilities of the coach are to assist the student to adapt to the different styles in individual situations.

### Supervisor

This term is used for experienced midwives who train students. Though the relationship can be hierarchical, meaningful communication and interaction between supervisor and student can reduce the hierarchical state (Gardiner, 1989).

A supervisory role is dependent upon the type of relationship formed between the supervisor and the student, and recognition by the supervisor of the differences between students in learning tasks (Gardiner, 1989). There is, in this recognition, congruence between the

supervisor and the student's views, both personally and for professional practice. To demonstrate congruence, the supervisor will need to be credible in practice to bridge the relationship between theory and practice (Jarvis, 1984). Butterworth and Faugier (1992) see the supervisory relationship as one of growth and development that provides support for developing clinical autonomy and is necessary for ensuring professional accountability (Bishop, 1994). To be responsive to a student's level of learning means that the supervisor must be responsive to his or her own learning with continuing education and professional development (Butterworth and Faugier, 1992). Being aware of new forms of practice through self-development, a supervisor can encourage enquiry by exchanging ideas with the student. Recognition of a student's opinions and views can build a relationship of trust and reliability (Butterworth and Faugier, 1992). The supervisor, therefore, promotes an environment for the student to become self-aware.

### Facilitator

This role encourages students to question and to challenge assumptions with reflection upon their learning (Brookfield, 1986). This role is one of acting as a learning resource by a person who is experienced in a speciality and who will have patience for the student to be self-directed, but will intervene when necessary (Morton-Cooper and Palmer, 1993). Ogier (1989) suggests the facilitator does not have to be the 'fount of all wisdom, but rather to be the creator of a learning climate in which others are able to contribute' (Ogier, 1989:74.). In being a facilitator the teacher or practitioner can contribute to the student's learning through communicating, responding, asking questions, and showing interest in the other without judgement. Also, through confirming with the student her learning achievements, the facilitator is pivotal in the process of relevance and accurate interpretation (ibid.).

### Assessor

The assessor has two roles, one as a gatekeeper to the standard of entry to the profession with measurements of terminal assessments and the other as a guider in the processes of the assessment. Though this second function is important, emphasis in higher education is given to the former. One role of the practitioner is that of a clinical assessor but this can conflict with the role of caring for woman and child. It is a task which requires skill (Jarvis and Gibson, 1987). Because the wish to achieve success in assessments is a strong motivation to student learning the student relies on the guidance of the midwife (Ramsden, 1984). The assessment strategies are where the educators can provide advice and guidance to promote growth in learning (Birchenall, 1985).

Where there are clinical practice tasks to complete, the assessment and the role of the assessor can become obtrusive as both can occur within artificial circumstances. An unobtrusive assessment process occurs when the practitioner works continuously with a student with interaction, that is both non-verbal and dialogical (Rowntree, 1987). Unobtrusive feedback is dependent upon the willingness of the assessor to provide it constructively and the willingness of the student to receive it. Students' motivation to negotiate and to identify their own processes for assessment may depend upon their interactions with and the willingness of the educator to give constructive comment.

Conflict arises when an assessor disregards her role in assessment and does not meet the students' requirements, or when the student fails to negotiate with the assessor the specific requirements. This can result in a breakdown of trust between the practitioner and the student, or the practitioner and the teacher. Where trust is lacking, an assessment is seen as a major threat though where there is an effective level of communication between teacher and

clinical assessors conflicts are reduced (Fraser et al 1997, 1998). The role of the clinician in education of students reflects the characteristics outlined above as mentor, coach, facilitator, supervisor and assessor and combining these roles raises the complex attributes required of the practitioner.

### **The role of the teacher**

The teacher's role is twofold, one as a teacher within an academic institution and the other a link between the academy and the health service, to bridge the many complex issues of theory and practice. There is often a conflict of loyalties and workload for teachers in combining these roles. Similarly there is difficulty in maintaining a clinical expertise (Clifford, 1993; Clifford, 1996). The main role of the teacher is as an academic (Phillips, Davies and Neary, 1996). As academic, the teacher has a mastery of her subject, and as an educator of students as supervisor, facilitator and assessor, discussed above. There is a responsibility for lecturers to be conversant with contemporary practice and the subject area (Day et al, 1998). There is an expectation that lecturers guide and contribute to the assessment of students in practice (Fraser 2002a). The teacher inspires and imbues a sense of direction for the student (Brookfield, 1990). Knowledge of contemporary practice with its evidence and research gives credibility and respect. In both areas, authenticity and credibility (ibid.) are achieved by being visible in the practice area and through a dialogue emerging between teachers, practitioners and students (Day et al, 1998). Trust and respect are conveyed through interpersonal skills (Jarvis and Gibson, 1987; Day et al, 1998). Recognising student's ideas and accepting their contributions and creating a climate of participation promotes trust

(Whittock, 1997). Performance in practice, words and action need to be congruent (Brookfield, 1990). Though the teacher gives a theoretical explanation in the classroom, it is when these are interpreted by the student, within the practice components, that understanding occurs.

Development of a policy for the role of lecturers when in practice, depends upon agreement at all levels of the academic and health organisations (Crotty, 1993; Baillie, 1994). Unless there are formal agreements between health and education services, the academic has no authority over standards and quality of practice (Lathlean, 1992). In the classroom, students learn principles and theories of practice, but they also learn from experiencing activities and through explanations by the teacher or practitioner. If the teacher or facilitator displays idiosyncrasy and arbitrariness in a one-to-one basis, this can give a biased view to a student or deter her motivation and adaptability to learning (McIntyre, Hagger and Wilkin, 1993). The role of the academic in practice can assist the promotion of an appropriate learning environment.

## **Conclusion**

Becoming a midwife involves the process of a student mastering the art of her practice. Dialogue and personal interactions between lecturers, practitioners and students, influence a student's learning. It is this process in the curriculum, which is covert and difficult to articulate. A midwifery curriculum uses different models to ensure that professional

requirements, learning and teaching strategies are met in a balanced way to bring together the goals of both the sectors of health service and higher education. The roles in learning are complex and the relationships and roles of both the teacher and practitioner require clarification to ensure their mutual co-operation and collaboration to set the environment for students to meet their learning achievements. The roles of both are clouded by differences in terminology and both require clearer clarification as to their purpose and function. The roles of lecturers and practitioners are complementary in student learning, and though both have a distinct role, they can both affect the course of students' learning experiences.

Midwife lecturers and practitioners are influential, but the impact of learning is through clinical experience with woman and child, and other professional contact. Both the lecturer and the practitioner are pivotal through their interactions with the student, and with each other, and lines of formal communication promote a dialogical relationship that can stimulate self-direction and reflection in learning. Repetition of learning experiences develops confidence and safety in practice, but learning opportunities come through recognition of multiple experiences. Students cannot practise with mastery unless they have the appropriate knowledge to use in practice.

In any exploration of the context of a student's learning, it is apparent that teachers and practitioners have multiple roles in facilitating this process. Furthermore students also have complex and multiple roles in acquiring their learning. Not only are the roles of the teacher, practitioner and student complex but these roles are reflected through the individual relationships that students form with their educators. Discovering the relationships that are

formed to effect and promote learning and those that negate learning within these multiple roles will aid an understanding of development of a curriculum and advance student learning. This section, with chapters 3, 4 and 5 has identified issues for exploration of learning relationships. The key areas emerging from this analysis of the literature are the role of being a professional; the role of the client in professional learning; notions of accountability and responsibility in relationships; communication between professionals; perceptions of knowledge and skills; the value of clinical practice; perceptions of roles and responsibilities in student learning and roles of educators. These provide the foundations for illumination in the empirical study. The next section, chapter 6, gives the rationale and details of the empirical work undertaken in this exploration.



## **6 The enquiry**

### **Introduction**

This chapter sets out the nature of the enquiry and the framework for the investigative approach. The context of midwifery education informs an analysis of the constructs within which relationships are formed. Concepts analysed in the previous chapters of midwifery professionalism, knowledge, professional education and its curriculum, are the context for this exploration. Relationships are explored through the differing perspectives of the triad, composed of the teacher, the practitioner and the student. The purpose of the study is to generate a substantive theory of relationships in pre-registration midwifery education. This chapter justifies the methodologies and amplifies the empirical processes. Grounded theory was chosen as a methodology for the exploration as this was hitherto an unknown topic area in the field of midwifery. Grounded theory is an approach to research that enables illumination and exploration, thus discovery of a subject area (Strauss and Corbin 1997; Strauss and Corbin 1998; Strauss and Corbin 1990). Relationships are made within the social world of people and the work of Blumer (1969), on symbolic interactionism informed an understanding and the analysis of the nature of relationships in this study. Grounded theory methodology elicits 'the social meaning of their (participants) actions' Melia (1982:329) and it is a constructivist approach with the epistemology based on the understandings of symbolic interactionism and the meanings of others, with integration of literature, thus this methodological approach was considered appropriate to explore the purposes of the study.

### **Aims of the study**

The aim of the study was to examine relationships between the triad of the teacher, the practitioner and the student. It aimed to identify components that build positive learning relationships, and that enable a student to learn so as to practise on completion of the

course. This study includes those influences that facilitate and constrain relationships. The central focus of care in midwifery is the mother and child, and an integral part of the study was to explore the influence of this dyad on relationships within the triad, relevant to student learning.

Following an initial phase of exploration during a period of participant observation, in phase one of the study, the following hypothesis was formulated: that knowledge and skills gained by students, so as to become competent in midwifery practice, are influenced by the relationships between teacher, practitioner and student. This was a basis for the empirical work. The above hypothesis generated the following subsidiary questions that provided a framework for illumination within the study:

1. Whether relationships between teachers, practitioners and students affect student learning?
2. If, when beliefs for midwifery practice held by midwife teachers and practitioners are similar whether the student has:
  - a) an enhanced likelihood to learn effectively, and
  - b) adopts learning strategies for different types of learning?
3. Whether frequent contact and dialogue between midwife teachers and practitioners of the profession:
  - a) assists the student to interpret theory with practice and
  - b) assists the student to make sense of her experiences?
4. Whether divergence of ideals and beliefs between the midwife teachers and practitioners causes conflict and anxiety in students and if this can inhibit learning?

These questions, by their nature, indicate a study that explores phenomena surrounding human experiences and that gains information from perspectives of phenomena that form human interactions (Blumer, 1969). Using the hypothesis and questions that emerged from the initial data and subsequently from each phase of data collection, as a guide to the research design (Strauss, 1987), the methods chosen were to fit the purpose of acquiring exploratory data (Hammersley and Atkinson, 1983). For example, qualitative approaches for gathering exploratory data were used through observations, questionnaires and interviews. Qualitative methods aid exploration of the social world and the perceptions and experiences of human phenomena (Hammersley and Atkinson, 1983). Therefore the study, though bounded by interpretation of human perceptions, was placed within the context of the organisational settings, therefore the social world of students' learning. Understanding of the reality of the social context of the empirical research provided a background for data analysis. Therefore the approach taken, through a qualitative exploratory study, was to obtain an ontological and epistemological perspective by generating data in three different ways, in varied settings. Participant observation was used to develop an initial understanding of the issues. Subsequent data collection used open questionnaires and in-depth interviews to test and verify the emergent theory, with a comparative analysis of theoretical frameworks with the emergent themes. This was a constant comparative method where data is confirmed and compared at each stage of the research process, in this study between each method used and each phase (Hammersley, 1990). Content analysis was used for interpreting the weight of opinion of the qualitative data, thus utilising quantification of data (Blumer, 1969).

### **The nature of the enquiry**

A grounded theory approach described by Strauss and Corbin (1990) was used, whereby the researcher is guided by the data that emerges and integrates this with previous theory and subject matter (Glaser, 1978). This approach explores the reality of the social world,

in this case the world of midwifery education. The approach is historically based on the work of George Herbert Mead and Herbert Blumer of the Chicago school in social psychology who explained symbolic interactionism (Blumer, 1969,1980). Grounded theory is sometimes referred to an interactionist approach. Symbolic interactionism is a way of understanding the world through shared meanings that result from interactions between people. Grounded theory is an approach that attempts to explain situations and phenomena that are not well understood. It demonstrates the meanings and actions of people in their environments and recognises the importance of the context of situations, thus the environment is relevant to the theory building. The approach was appropriate to this study. The researcher uses knowledge and experience of the subject area and through a process of sensitisation, informs and creates the emergent theory (Strauss and Corbin, 1990; 1997). Sensitisation was a process used by the researcher to develop a knowledge of literature and using both professional and personal knowledge, and personal experience gained insight of the subject area, whilst, at the same time, was able to reflect and be sceptical about the emerging data (Strauss and Corbin, 1990).

To build theory in this enquiry the process required a systematic process with analysis at different stages that integrated the empirical work with already known frameworks of theoretical knowledge (Strauss and Corbin, 1990). This study was specifically concerned with human perceptions of phenomena associated with relationships and the impact of changing organisational structures that impinge upon students' learning. The impact of organisational change, altering norms and rules which affect peoples' interaction, was part of Blumer's (1969) methodological perspective in exploring human behaviour.

Sensitivity to the literature was an important consideration, that is, to select appropriate areas and explore new avenues as the data emerges, for relevance and testing against developing concepts. This was ongoing throughout the study and is demonstrated in sections 2 and 4. A theoretical sensitivity to subject matter (Glaser 1978; Strauss and Corbin, 1990) produced a continual process of iteration between theoretical and empirical

work to aid interpretation and integration of the data. It included using personal and professional experience to look at the data from different angles. The exploration of the theoretical constructs was informed by the data and the background experience of the researcher. The presentation of the empirical data was tested against theoretical frameworks, with the concepts derived from theory. Thus, a process of checking and reviewing the data with the literature resulted in refining the emerging categories in questionnaires and interviews at each stage of each phase in the light of emerging data.

To uncover assumptions in use in midwifery education, a review of twelve curriculum documents from 11 institutions with diploma and degree programmes, which had been submitted for validation, were analysed using the explanation of content analysis by Krippendorff (1980). It is interesting to note a similarity of findings with Fraser et al (1997, 1998) who found that 23 curriculum documents were written following the English National Board guidelines rather than being written for the users of the curriculum. In this analysis of 12 documents, only one was written for use by educators, practitioners and students following validation, the other 11 followed the guidance by the English National Board. The analysis of documents was used for the framework of theoretical exploration in chapter 5. This research technique uses text to make replicable and valid inferences from large amounts of data (Krippendorff, 1980). It is systematic, objective and attributes symbolic meaning to selected units of the text, which can then be measured (Cavanagh, 1997). Texts were coded and these were clustered with the meaning compared to the concepts in the literature.

The context, in which this study took place, was at a time of major change and therefore the design required flexibility so that the researcher responded to new and different forms of data that emerged (Strauss and Corbin, 1990). At the same time, constancy for comparison, had to be ensured for trustworthiness of the emerging data and analysis (Strauss and Corbin, 1990). The concepts for the design emerged, in the initial phases of the study, through participant observation, exploratory questionnaires and interviews, and

a literature review. Comparisons were made of differing educational institutions in four phases of the study, though as data emerged from each site there was iteration of conceptual development between the phases:

- phase one: an exploratory phase to develop initial concepts and raise the initial hypothesis and research questions;
- phase two: initial data collection and formulation of emergent categories;
- phase three: further data collection for comparison and redefining of emergent categories;
- phase four: further data collection to verify and test the framework emerging.

Although the data collection tools and analysis were the same for phases 2, 3, and 4 this created different sets of data to contrast. Data were coded and categorised at each phase. Categories were reformulated and a framework rebuilt at each phase of the study until each category was saturated (Glaser and Strauss, 1967). Saturation is when categorisation is dense and no new data can be added and the relationship between the categories is saturated (Strauss and Corbin, 1990). There was a dialogical relationship between the emergent theory and the data. The phases were not discrete, thus allowing revisiting of data whilst moving to the next phase. The stages of development of the analysis for the substantive theory used in this study are adapted from Strauss and Corbin (1990) and Barlett and Payne (1997) in table 19 (page 163) which demonstrates the process in conceptual development.

**Table 19: The research process stages in the development of a substantive theory**

Stage of theory development	Stages in the Research process	Literature review	Phases of study in analysis of data
1.	<b>Collection of data</b> - qualitative - quantitative	Review initial concepts	Phases 1,2,3,4,
2.	<b>Transcribe data</b> - add memos and notes		Phases 1,2,3,4
3.	<b>Simple/ initial coding</b> First level coding of categories (link with theories)	Review literature for new concepts	Phase 1 and 2 initially for first level coding Phase 3 and 4 at second level coding
4.	<b>Axial coding</b> - link with constructs and categories - develop theoretical sensitivity		Phases 3,4.
5.	<b>Saturate categories</b> Refine and alter Second level coding of categories		Phases 3, 4
6.	<b>Abstract definitions</b> Selectively code with refinement Define properties and dimensions	Link with literature	Phases 3, 4
7.	<b>Conditional matrix</b> Tracking events with links between individuals, departments, institutions and nationally		Phases 3, 4
8.	<b>Theoretical sampling</b> Verification of data and ensure saturation		Phase 4
9	<b>Definition of core categories</b> (further reduction) - link with theoretical sampling, and abstract data		Phase 4
10	<b>Abstract data to develop theory</b>	Review categories core with theory.	Final analysis

Adapted from Strauss and Corbin (1990) and Barlett and Payne (1997)

Iteration between each stage of each phase above aimed to develop rigour in the analysis and theory development as suggested by Miles and Huberman (1994).

## **Developing the empirical research**

### **Profiling Institutions for the Study**

At the time of collection of data there were 70 centres of midwifery education within higher education. Four institutions were approached with one in each demographic area as follows:

- An urban district area;
- A suburban metropolitan area;
- An outer urban metropolitan area;
- A rural district area.

Differing demographic locations were chosen for contrasting characteristics of demography and organisation to reflect national variations in educational programmes. Variations were three year or eighteen months courses; degree or diploma level courses; rural versus urban settings; institutions with links with universities or polytechnics/new university and different geographical locations. Comparing different settings using the same methods of research aids verification of developing conceptual frameworks. A schedule for developing profiles of education departments is given in appendix 3. Preferred institutions were those that offered both traditional courses and that had implemented, either before or during the study, a diploma or a degree programme.

Institutions were approached in 1992 to obtain permission to undertake the study. Profiles of the institutions were completed when they were visited for the empirical research. A summary of which is given in table 20. :



**Table 20: Profiles of Institutions: summary of characteristics**

<b>Characteristics</b>	<b>Institution W</b>	<b>Institution X</b>	<b>Institution Y</b>	<b>Institution Z</b>
Geographical area	Urban	Metropolitan	Suburban	Rural
Type of institution	College merging with old university	Polytechnic	College merging with new university	New university
Structure for midwifery education	Department of midwifery education	Department of midwifery education	Department of midwifery education	Department of midwifery education
Holder of responsibility for midwifery education	Head of midwifery education who referred to head of nursing	Head of midwifery education	Senior Midwife Teacher as Head of midwifery education for student midwives	Head of midwifery education
Numbers of teachers involved in student midwife training	8	23	7	10
Number of teachers who held teaching qualifications	8	19	7	10
Number of teachers with clinical commitment	8	19	7	10
Number of teachers with personal midwifery student responsibility	8	12	7	10
Number of clinical sites linked for education	5	7	2	5
Distance between education centre and clinical sites in miles ( min – max)	3 - 23	0 - 10	1- 10	1- 40
Length of student midwifery training offered	18 months	18 months and 3 years	18 months	3 years
Service commitment of students	40-60%	50%	50%	40-60%
Decision making about student numbers	Head of Midwifery Services	Head of Midwifery education with health consortium	Head of midwifery services	Contract between Health Trusts and Regional Health Authority
Termination of students' contracts	Head of Midwifery Services	Head of Midwifery Education	Head of Midwifery Services	Head of College of Nursing and Midwifery

The profiles, summarised in appendix 4, formed part of the notes and memoranda supplementing other methods of data collection (Strauss and Corbin, 1990;1998). The contrasting organisational characteristics shown in table 21., expanded in appendix 5, formed comparisons between institutions.

**Table 21: Characteristics of midwifery education organisations**

- Type of Institution
- Departmental structure
- Responsibility for midwifery education
- Role of the midwife teacher
- Number of midwife teachers
- Links of teachers with clinical areas
- Formal links with Health Authorities
- Numbers of midwifery units for student placement
- Proximity of midwifery education sites to clinical sites
- Formal arrangements for clinical and service link

These characteristics, indicative of each organisation's structure were referred to during the analysis of categories, and when abstracting a framework for relationships.

## **Research approach**

This qualitative descriptive research provides a rich description (Miles and Huberman, 1984). It was exploratory, in that it illuminated views and perspectives of complex

situations, and used an ethnographic approach for collection of interview data (Agar, 1986), that is:

‘you need to learn about a world you don’t understand by encountering it first-hand and making some sense out of it.’

(Agar, 1986:12)

This gave opportunity for detailed exploration, using forms of discovery and verification (Strauss, 1987) with both deductive and inductive approaches in the analysis (Strauss and Corbin, 1990).

To reduce bias three qualitative methods, observation, questionnaires and interviews were used to collect data and test against each other, using triangulation to confirm the data. This was in the four phases. The importance of such a multi-layered approach is that the different sets of data provide a measure of internal validity (Bradley, 1995). This is possible in areas of data that were segmented and gave comparison between the different methods. The main purpose of triangulation in this study was to aid completeness of the data (Knafl and Breitmayer, 1991) and give complementary views from different data sets, providing data triangulation that provides the researcher with more confidence in the findings.

The study included a survey using questionnaires of closed and open questions (Cohen and Manion, 1994). Responses to open questions are dependent upon interpretations by both respondent and researcher. There are limitations to open questions as they produce a variety of responses and cannot be controlled, giving a complexity of views (Oppenheim, 1992). They are subjective and interpretive. However they were purposefully used in this study as the complexity of views would illuminate the questions to be asked for

further clarification in interviews. The purpose of a grounded theory approach is to raise questions and to prove or disprove them as the analysis progresses in building a theoretical explanation (Strauss and Corbin, 1998; Corbin and Strauss, 1990). Questionnaires provide a source of data for analysis, that can be deciphered and clarified where the subject area is complex (Cohen and Manion, 1989).

Interviews using a semi-structured schedule (see page 187) gave an opportunity for in-depth questioning that could probe and clarify respondents' meanings. A feature of this type of study is that the interpretation is through the eyes of the researcher that results in partiality. However, the advantage of interviewing is that issues can be revisited. The meaning of a respondent's replies can be elicited by, either asking questions in alternative ways, or requesting examples to illustrate views.

The researcher becomes an instrument in the process of data collection and analysis, but an important aspect is the trustworthiness and rigour of the researcher (Lincoln and Guba 1985). A benefit where the researcher is a professional, with a direct knowledge of the field of study, is that she has prior insight into the subject area (Strauss and Corbin, 1990) recognising events and situations that respondents present. McCracken develops the idea further of 'self as an instrument' by referring to the researcher as 'rummaging through his/her own experience to match data' (McCracken 1988:19-20). This reconstructing the world from the respondents' views can be compared to 'bracketing,' where one acknowledges and is cognisant of one's own feelings and biases, to provide objectivity (Lipson, 1991). In reality it is difficult to identify all one's own feelings and preconceptions (Gadamer, 1977), though it is possible, through careful reflection, to identify personal views and orientation that could influence the interpretation of the study.

## Cross site analysis

Using different sites with comparison gave rise to an emergent theory which was tested and refined in subsequent settings in four phases. Table 22. gives the methods used within the four phases which are discussed in the subsequent pages.

**Table 22: Methods used in the four phases of the research process**

Phase	Institution	Method of research
Phase 1	Urban district	<ul style="list-style-type: none"><li>• participant observation</li></ul>
Phase 2	Suburban metropolitan	<ul style="list-style-type: none"><li>• convenience sampling with interviews and questionnaires</li></ul>
Phase 3	Outer urban metropolitan	<ul style="list-style-type: none"><li>• convenience sampling with interviews and questionnaires</li></ul>
Phase 4	Rural district	<ul style="list-style-type: none"><li>• purposive sampling for questionnaires and interviews</li></ul>

The research process in each phase was not discrete. There was a constant checking and rechecking of the emergent themes with the data and literature intra and inter phase. Following the first phase, a sampling framework for setting the parameters of the study, as suggested by Miles and Huberman (1984), was adapted (appendix 6.).

## The settings

The settings for the study were one, the clinical areas of the maternity units where students gain practical experience. Two, the classrooms and three, administration offices. Meetings with participants in the study took place in those settings, for incidental discussion and for interviews.

### *Phase One: exploratory to develop initial concepts*

In this exploratory phase during a two week period of participant observation, in one institution, in both educational and clinical settings, the researcher noted occurrences and interactions whilst observing the groups for study. Primary data were collected using a diary of observations and events and a daily reflective summary. Informal discussions were held with the three groups when notes were taken. Themes from the diary, the notes and the reflection formed a first set of categories, through open coding and clustering, which, with the literature, informed the development of the methods for the following research. The data were analysed to formulate the initial concepts for the study.

### *Phase Two: formulation of initial categories*

A different institution was used to formulate codes and themes for analysis from the primary data. The data collection methods were tested and refined. Subsequently collection of data from the three sample groups were analysed using open coding using Strauss and Corbin's (1990) discussion of labelling phenomena to form an initial framework of relationships.

### *Phase three: redefining the emergent categories*

Emerging categories were redefined and reformulated. This phase of data collection used the largest sample group to develop an emergent theory. During analysis, further categories were developed, though others were saturated, that is, when a category is fully developed with no new information emerging in the subsequent data collected (Strauss and Corbin, 1994). An example is in the category develop of 'personal traits' where the code 'respect of each other' was a feature of a learning relationship raised in 47% questionnaires and by many of the interviews of the three groups.

### *Phase four: testing and verifying the framework*

A contrasting site with distinctly different characteristics was used for theoretical sampling (Strauss and Corbin, 1990) and to test the framework. Theoretical sampling uses informants who demonstrate the social characteristics relating to the research question (Strauss and Corbin, 1990,1998), and in this case were those who met the criteria for the sample group. Therefore, key informants of each sample group were selectively sampled, using a purposive sample, until saturation of the main categories. There was opportunity to explore certain areas in depth and to confirm gaps in the data (Strauss and Corbin, 1990). Categories were refined with core categories emerging, that is, a final category as an emergent theme for analysis, such as 'personal traits' with subcategories such as 'respect for each other'. Using a guide by Strauss (1987) interview respondents in this phase were asked to verify emergent data by asking them, at the completion of the planned interview to discuss, to refute or confirm the emerging frameworks. The frameworks were outlined and discussed with respondents using charts, figures and graphs. This aims to enhance the rigour of the study (Mays and Pope 1995).

The sample groups

Three groups formed the population. These were (i) midwife teachers, (ii) clinicians and (iii) students:

#### *Teachers*

The criteria for selection of the midwife teachers were that they taught student midwives and currently had a personal responsibility for them. The total sample in phases two, three and four was 29 but in phase four, following a meeting with the full group to discuss the study, five teachers were chosen as key informants to be representative of the total group to be used for theoretical sampling. These five teachers, who met the above criteria, were used to confirm the emergent theory giving a sample size of 24. Table 23. gives the teachers' response rate to the questionnaires and the number who were interviewed in each phase.

**Table 23: Teachers' questionnaire response rate and number interviewed**

<b>Phase of study</b>	<b>Total sample</b>	<b>Questionnaire response by institution, numbers and percentages of the sample</b>	<b>Number of teachers interviewed in each phase</b>
Phase 2 (two sites)	12	12 (100%)	3
Phase 3 (two sites)	7	7 (100%)	7
Phase 4 two sites	5	4 (80%)	5
<b><u>Total</u></b>	<b>24</b>	<b>23 (96%)</b>	<b>15</b>

Table 24. gives the characteristics of teachers who responded to the questionnaire, one respondent did not return the questionnaire in phase four giving a response of 23.



**Table 24: Characteristics of teachers in the study.**

Characteristic		Phase Two	Phase Three	Phase Four	Total No. (%)
Years of practice as a midwife prior to teaching	Years:				
	1-5	5	2	2	9 (39%)
	6-10	5	2	-	7 (31%)
	11-20	-	2	1	3 (13%)
	21 and over	2	1	1	4 (17%)
Years of teaching students	Years:				
	1-5	5	3	3	11 (48%)
	6-10	4	2	-	6 (26%)
	11-20	2	2	-	4 (17%)
	21 and over	1	-	1	2 (9%)
Approximate hours of clinical commitment per week	Hours:				
	4-7	5	2	3	10 (44%)
	8-10	4	-	-	4 (17%)
	Over 10	2	-	-	2 (9%)
	Non specific /varies	-	4	-	4 (17%)
	no response	1	1	1	3 (13%)
<b>Number of responses</b>		<b>12 (52%)</b>	<b>7 (31%)</b>	<b>4 (17%)</b>	<b>23 (100%)</b>

### *Practitioners*

In phases two, three and four clinical midwives from two associated hospital sites, where students received their training, formed the total sample groups. Midwives who were currently practising and who worked with students were eligible for the study. Those who were in practice at the time of the study were given the questionnaire. This excluded midwives who had holiday, sickness or maternity leave. This gave a total sample of 249 in the three phases. In phase four 5 midwives who met the criteria were selectively chosen from each site for interview. This selective sample of those who were representative of the total sample group was used for theoretical sampling. A meeting was held with staff to discuss the study. Of the midwives who volunteered, in collaboration with the Heads of Midwifery, five midwives were chosen from each site, to

be representative of the characteristics of the midwives in the maternity unit. Table. 25. gives the practitioners' responses to the questionnaires and the number who were interviewed in each phase.

**Table 25: Practitioners' response rate to questionnaires and number interviewed**

Phase of study	Total sample	Questionnaire response by site	Questionnaire response by institution, numbers and percentages	Numbers of practitioners interviewed in each phase
Phase 2 (one sites)	56	18	18 (32%)	7
Phase 3 (two sites)	112	31 and 27	58 (52%)	15#
Phase 4 (two sites)	80	30 and 18	48 (60%)	11
<b>Total</b>	<b>249</b>	<b>124</b>	<b>124 (50%)</b>	<b>33#</b>

# 2 paired interviews

The response rate to the questionnaire in phase two was poor. It was discovered later that the midwives did not consider that the questionnaire related to their work and therefore did not respond. As a result of this the researcher remained in the institutions on a daily basis during phase three and a weekly basis in phase four whilst the data was being collected, to enhance the response rate. Once the questionnaire overall response rate had reached 50% in phase three; that the responses were representative of all groups (see table below) and the analysis demonstrated that the emerging categories in the data were saturated, it was decided that this would be an adequate sample upon which to base the findings that were to be theoretically sampled and verified in the next phase. Table 26. gives the characteristics of the practitioners who responded to the questionnaire and who were interviewed.

**Table 26: Characteristics of practitioners who responded to the questionnaire**

Characteristics		Phase Two	Phase Three	Phase Four	Total No. (%)
Number of year of practice as a midwife	Years:				
	1-5	8	29	16	53 (43%)
	6-10	2	13	9	24 (19%)
	11-20	4	14	17	35 (28%)
	21 and over	2	2	4	8 ( 7%)
	No response	2		2	4 ( 3%)
Grade of Midwife	H	1		1	2 ( 2%)
	G Hospital	1	14	14-	29 (23%)
	G. Community		22	16	38 (31%)
	G Combined	9			9 ( 7%)
	F	6	17	13	36 (29%)
	E		5	4	9 ( 7%)
	D	1			1 ( 1%)
	No response				
Number responding from Special care Baby Unit		2	1	1	4 ( 3%)
Numbers holding teaching in clinical practice qualification		7	14	8	29 (23%)
<b>Responses of questionnaires per phase</b>		<b>18 (14%)</b>	<b>58 (47%)</b>	<b>48 (39%)</b>	<b>124 (100%)</b>

### *Students*

Two cohorts of students from each institution were selected for the sample. This gave a total sample of 106. One cohort in phase two did not respond as a group, as they were protesting about their results of their course. In phase four one group who were working on the community returned only four questionnaires. Following a group discussion of the

purpose of the study students were asked to volunteer for interview. Students in the cohorts volunteered themselves for the interview. Their participation was discussed with their lecturer. In phase four a selective sample, for theoretical sampling and verification the emerging framework, of five students was chosen for the interview from among those volunteering. Table 27. gives details of the students who responded to the questionnaires and who were interviewed.

**Table 27: Student Midwives' response rate to questionnaires and number interviewed**

Phase of study	Type of training	Months of training completed	Total sample	Questionnaire responses by institution: numbers and percentages	Number interviewed in each phase
Phase 2	18 month Diploma	14 months	26	13 (50%)	3
Phase 3 (Two sites)	18 month Diploma	8 months 14 months	36	9 (53%) 10	6 5
Phase 4 (Two Sites)	3 year Diploma 3 year Degree	12 months 24 months	44	4 (27%) 8	3# 4
<b>Total</b>			<b>106</b>	<b>44 (42%)</b>	<b>21#</b>

# 2 paired interviews

## Events

Events were the contacts made between each group for learning relationships; their frequency, nature and type of contact. The meaning of events must be understood from the perspective of the participants (Chenitz and Swanson, 1986). This was aided by the

researcher being able to understand the language of the respondents with an insider knowledge. 'Listening' to respondents and asking them to clarify their meaning was a way of gaining their perspectives. Data were gained on the formation of relationships, and on networks and communications.

### Processes

The processes identified in relationships were those that affected interactions between the different groups, such as personal communications; learning strategies; student contacts with mothers; contacts between midwives and teachers; informal discussions and formal teaching sessions. Areas in which students learn knowledge and acquire skills through relationships were also explored through the interviews with the three groups of actors. The investigation was to elucidate processes involved in the types of relationships that aid learning complex skills as these were raised in the questionnaires. Further information was sought in the interviews.

### **The research process: procedural and ethical issues**

Written applications were made to the gatekeepers of each institution both in education and clinical settings (Cormack, 2000). These were made to the heads of midwifery education and heads of midwifery units in 1992 to undertake research in each of the four sites. Local Research Ethics Committee approval was not required in any of the sites as the study did not involve clients but managerial approval in host education and health institutions was required and agreed for the study to be undertaken.

A meeting was held with the heads of education and midwifery services of the institutions to discuss the study and its methodology. Further arrangements were made to meet with individual groups of teachers, clinical staff and students to discuss the study, its protocol and methods and to seek their participation. Several meetings were held with the

different groups on each site, both education and in the maternity units. This included day and night staff, community and special care baby unit staff as well as different groups of midwives in the hospital. Arrangements were made to meet with each cohort of students. A protocol outlining the study was given to those who attended the meetings. This occurred within each phase of the study.

Arrangements were made in phase one for the researcher to be attached to midwives in the clinical areas and to be present on study days with the students. The protocol was available for those who required information about the study. Plans were made for distribution of questionnaires with the different groups to suit their local circumstances. A description of the study was available for circulation with the questionnaire. Participation was voluntary, for both questionnaire and the interview. Responses to the questionnaire were encouraged by the regular appearance of the researcher in the clinical area. Collecting boxes for completed questionnaires were made available. The week before the final return date for the questionnaire a reminder letter was sent with a second questionnaire. This aimed to increase the response rate (Brook 1978).

A written outline indicated that interviews would be conducted with a tape recorder. The researcher/interviewee relationship was one that needed careful setting-up so that there was a free exchange of information. Letters used for the study are in appendix 7.

Particular ethical principles required attention in completing this research. These were beneficence, nonmaleficence, respect, justice, consent, confidentiality, privacy and anonymity which are considered in the discussion below. Beneficence is being able to contribute some value to the respondent who voluntarily gives of their time. This subject was not one many had actively thought about prior to discussion in the participant observation, the questionnaire or interview and some respondents found the subject

relevant to their work whilst others appeared to find the interest in their views worthwhile. In undertaking research of this sensitive nature nonmaleficence concerns not exposing the respondents to personal risks (Polit and Hungler, 1997), thus this required vigilance in questioning and responding to the respondents. An example was a student who found her current arrangements with her mentor untenable leading her to decide to abandon her training. It was important here not to exacerbate the situation through questioning her about the situation but to concentrate on the issues of the study. The researcher is engaging with the private lives of people (Silverman, 2001). In exploring relationships one is asking people to expose themselves and the issue required careful consideration before commencing the interviews (Miles and Huberman, 1994) by clarifying its nature and purpose and assessing the each participants willingness to participate. There is also a possibility of exploitation of the respondents if the researcher is not sensitive to the nature of questioning. Whilst one cannot estimate in a conversation the levels of harm occurring to another person, being aware of the implications of causing personal distress influenced the style of questions to each respondent. There is a level of trust that is assumed between the researcher and the respondents by the nature of their positions (Polit and Hungler, 1997; Miles and Huberman, 1994). This was demonstrated by the readiness and punctuality of the respondents for interviews and also by the apparent honesty of the responses. There were occasions when sensitive information was given that required understanding of the situation and not create harm. In a few student interviews it was necessary to suspend the interview to deal with a particular issue that emerged that was causing distress. It was important in these situations not only to maintain respect and confidence for the respondent and to try to assist in ameliorating the situation but also to have loyalty to the host institution. It was also important to ensure

that these episodes of suspending the interviews did not contaminate the conceptual analysis of the data.

All participants had full information about the study and management and staff agreement was sought prior to collecting data. During the participant observation any persons engaged in conversation about the study were given details of it. Conversations held with all groups were informal and information freely given. In order to demonstrate non-coercion or manipulation the respondents in both participant observation and the interviews were asked to assist in a discussion to uncover information hitherto unknown that is an exploratory conversation (Burgess, 1984). Confidential information, received during participant observation and interviews, such as, students having problems in their educational programme; student negative attitudes to their course programme, or personalities involved in their education, all required careful handling.

All data was anonymised during the analysis. The above principles of ethics apply equally to the analysis of the data and therefore all information was confidentially received. As the analysis of grounded theory emerges from the initial development of the literature and empirical data, there is a responsibility to ensure that no person can be identified within the processes of analysis. There is a commitment to develop the findings with honesty and integrity according to the information received.

The role and the dynamic of the relationship of the mother and her family, which could influence students' acquisition of knowledge and skills, were elicited through interview questions from the three groups. Students also gain knowledge and experience from other professionals and lay persons whom they encounter during their course programme,



particularly from events which are significant. The study did not seek to extend its remit to these casual meetings. The sample populations were drawn from the three groups only.

## Methods of Investigation

### Data collection

Data collection took place in the four phases. Table 28. summarises the stages involved in collecting data in the four phases.

**Table 28: The stages of the data collection**

<b>Phases</b>	<b>Stages in data collection</b>
<ul style="list-style-type: none"> <li>• Phase One</li> </ul>	<ul style="list-style-type: none"> <li>• Participant observation</li> <li>• collection of primary data - diary of events, notes and memos</li> <li>• review of the concepts through literature</li> </ul>
<ul style="list-style-type: none"> <li>• Phase two</li> </ul>	<ul style="list-style-type: none"> <li>• questionnaires and interviews</li> <li>• transcription and formulation of initial concepts and categories</li> <li>• link with notes and memos</li> <li>• review of the curriculum documents</li> </ul>
<ul style="list-style-type: none"> <li>• Phase three</li> </ul>	<ul style="list-style-type: none"> <li>• questionnaires and interviews</li> <li>• develop notes and memos during data collection and transcription</li> <li>• track events and saturate categories</li> </ul>
<ul style="list-style-type: none"> <li>• Phase four</li> </ul>	<ul style="list-style-type: none"> <li>• questionnaires and interviews</li> <li>• theoretical sampling and verification of data with respondents</li> </ul>

### Participant Observation (Phase One)

The decision to undertake participant observation was made as there was an advantage for the researcher, being an insider to the profession, to interpret meanings and experiences from a personal knowing of the situation (Burgess, 1984) but there is a caveat in

undertaking research in this way because of taking the situation for granted. As an observer, the researcher took the role of a student and was supervised during a refresher programme for a period of two weeks. Problems of role differentiation between researcher and those being observed, given the researchers' role as a student, may have changed the way the observed persons behave or respond. There is also danger of being too involved so as to see a clear and objective picture of the situation or being blind to situations (Silverman, 2001). This, according to Burgess (1984) can be overcome by being reflective. Therefore it was not only important to keep a contemporary record of reflections on the situation but to actively review and question the records made on a daily basis and to be honest about the research intention (Miles and Huberman, 1994).

In order to develop a framework for the study, interactions between teachers, practitioners and students were recorded. These were unstructured observations and discussions, and a diary of events was kept retrospectively for periods of one hour four times a day, and when significant events occurred, such as examples of particularly positive or negative interactions. To counteract problems of observations such as, only observing the issues that relate to a personal agenda (Kite, 1999); to overcompensate or misinterpret the data (Burgess, 1984); to be aware of the role differentiation affecting the honesty of responses, or to be oversensitive to observations and views (Bryman, 1998), the data was reviewed from an insider perspective but with a self-examination of a personal role and by questioning each facet of the data. Burgess (1984) suggests that this aims to increase objectivity.

This initial exploration led to a deepening of the focus of the study. The content and context of these observations were analysed for common themes that occurred in the

records, diary and reflective notes of the observations made. This led to questions and hypotheses from which themes for exploration were developed. The following themes were identified for further exploration.

### **Themes emergent from participant observation**

#### Components of relationships

Different kinds of components that form relationships between the three groups were manifested. These included personal, professional and educational abilities as well as interpersonal and communication skills. Issues raising further questions were the influence of these components in interactions, and their role in promoting either adverse or beneficial exchanges affecting student learning.

#### Nature of relationships

The nature of relationships that foster or hinder growth are influential in student learning. Learning may be dependent upon the degree of intimacy of the subject to be learned, or upon the type of relationship formed between student and educator. The nature of relationships appeared to vary according to the situation and experiences. Clarification of types of relationships such as those which are in harmony, or those of conflict, could give an insight into how students learn. Views were sought as to the meaning of the notion of relationships in the context of learning.

#### Role, responsibility and accountability for students' learning

Perceptions of respondents on relationships raised issues of roles, accountability and responsibility in learning. An attempt was made to determine whether perceptions and orientation to these concepts affected relationships between individuals of the three groups.

### Communication between the sample groups.

Different types of formal and informal group networks or organisational structures were evident. They formed the basis for individual contacts between the groups that could influence learning.

### Effects of geographical separation between service and education

Geographical separation between midwifery clinical services and education was a developing phenomenon. Education centres with the teacher's workbases were moved to higher education institutions. The impact of this on student learning and its relevance to the formation of relationships within the triad raised further questions to explore.

### Perceptions of knowledge and skills

Ideas on what knowledge is and what skills are and how these should be gained were raised. The appropriate style of relationship for student acquisition of knowledge and skills needed clarification. The kind of relationships that are necessary to convey confidence in practice was a further dynamic considered. Differences in midwifery ideals between students, practitioners and their teachers and the influence of this on students were explored.

### The role of the educator

Ideally the practitioner midwife acts as a role model for the student. The teacher was seen by students and practitioners as a person who provided theoretical instruction but who had different expectations of practice, from that of the practitioner. Perceptions of these roles required clarification as to whether the differences between these perceptions might affect the students' learning. Divergence in beliefs about practice held by teachers and practitioners may conflict with students' understanding of the theory/practice relationship and constrain their ability to be confident.

### The influence of the mother, baby and family in students' learning.

Students' relationships with the mother and family could be a catalyst in promoting learning. The mother or her family's response to the care received can also be a contributory factor to a student's learning. This may be inhibited or enhanced by either the mother's or student's relationship with the practitioner.

These themes were re-confirmed during the second phase of data analysis with the initial coding.

### **Questionnaires (Phases two, three and four)**

A structured questionnaire was adapted in design for all three groups. Comparative details of the sample groups were requested to obtain relevant personal details, such as qualifications, student course length, intake group, period of qualification or length into training course given in tables 24, 26 and 27. The questionnaires sought open information on the different groups' views of relationships and influences between teacher, practitioner and student. These allowed respondents to formulate their own responses (Parahoo, 1994). Respondents were asked to complete grids of their perceptions as to whether relationships were good or bad between each group of actors. The use of the words 'good' and 'bad' on the grids were value judgements, but they were purposefully chosen as these expressions of relationships are frequently stated in conversational language, particularly in relation to students' learning. The responses to this question provided a basis for an exploration in the interview. The majority of questions were open. Examples of the questionnaires for the three sample groups are in appendices 8., 9., and 10.

## Questionnaire responses

Table 29. shows the overall total responses for the questionnaire distribution in the study.

**Table 29: Summary of questionnaire distribution and responses for each sample group**

Sample groups	Total population	Sample population	Sample response	Percentage returned responses of sample population
Teachers	29	24	23	96%
Practitioners	332	249	124	50%
Students	126	106	44	42%
<b>Total</b>	<b>487</b>	<b>379</b>	<b>191</b>	<b>50%</b>

The questionnaire response rate was particularly low from the practitioners (32%) in phase two and from students in phase two and four. However, the responses received overall were representative of the differing groups of teachers, practitioners and students as shown in tables 24, 26 and 27.

A general comment was that respondents found the open ended questions time consuming and would have preferred a structured questionnaire using a menu type of response to improve the response rate. This alternative approach would have altered the type of data collected. Respondents felt that open-ended questions required time to answer and therefore some did not respond. In phase two practitioners did not respond well and as a result all subsequent questionnaires were given out personally following an introductory discussion. The response rate improved when there was a person on the site who could stimulate the questionnaire return. The overall response rate was 50% from the three groups.

## **Interviews.**

The role of the researcher was identified with the interviewees in the information sessions. In any interview the role of the researcher is influential (Miller and Dingwall, 1997). An attempt to reduce the differentiation of roles was made by using tactics to reduce the researcher/respondent divide. An example, was suggesting to respondents that they were assisting on a joint exploration and therefore there was no right or wrong answer, each point would contribute to ideas. There are also problems for the researcher in taking a lead and developing a bias in the questioning. To guard against this an interview inventory was devised from the themes developed during the initial phase (appendix 11.). This inventory was used as a checklist for all three groups to use with open questioning and provided a framework to probe issues in depth. An interview schedule also devised from the themes that emerged during the participant observation (appendix 12.) so that draft notes could be made during the interview. Use of a schedule with a framework aimed to minimise bias (Cohen and Manion, 1994) and ensure that similar ground was covered in each interview (McCracken, 1988), but it also allowed for each interview to follow its own course of investigation. Adaptations were made in structuring each interview that depended upon the individual respondents' answers. This allowed each interview to develop its own character through each interviewee's responses. The style suggested by Massarik (1990) was adopted, that is, whenever possible to probe in depth, explore and revisit points in questioning and invite exchange from the interviewee. Multiple perspectives were sought, using questions from a variety of angles and checking responses with the interviewee. Subsequent questions clarified the respondents' earlier remarks.

Interviewees volunteered and so were a self-selected convenience sample (phases two, three and four). Where possible, interviews were made by appointment with a letter confirming arrangements (appendix 7.). All interviewees were given assurances of confidentiality and anonymity. This helped to develop a sense of trust, that, in turn, helped to prompt spontaneity in responses to questions (Cohen and Manion, 1994). It was important to quickly establish a rapport with the interviewees and to gain their confidence. Sensitivity in questioning was important as references to situations could be construed as criticism of the institution (Woods, 1981). Being able to penetrate beyond ordinary talk and probe in depth (Adelman, 1981) was necessary to elicit the meaning of responses, particularly when respondents found it difficult to express themselves. Respondents attempting to articulate ideas that were new and not normally expressed often found this difficult. Using language that the interviewees could understand provided a medium for mutual exchange and encouraged the respondent to use technical language so that she felt free to express herself.

Finding an interview setting that was private, accessible, quiet, uninterrupted, away from the clinical area, though nearby, so that the interviewee could be called if necessary, was often difficult. A similar problem was identified by Woods (1981). Some interviews in the clinical areas were either interrupted or shortened because of this problem. Self-selected paired interviews were offered to respondents who were uncertain and uneasy about being interviewed (Cohen and Manion, 1989). The advantage of these interviews was that they opened up a wider range of questions and more issues were raised spontaneously (Morton Williams, 1978). Kerlinger (1979) suggests that interviews enable unexpected results to be exposed and enquiry occurs in more depth, which, in this study, exposed areas of conflict in relationships or difficult personal interactions.

Interviewees were asked to complete the questionnaire prior to interview to give the respondent some insight into the issues being discussed at interview. Both the purpose of the study and comments on the questionnaire were discussed at the opening of the



interview. Interviews were between 30 and 75 minutes. Agreement was sought from all respondents before recording the interviews. A small tape recorder was tested for voice production at the beginning of the interview and this exercise was used as an 'ice breaker'. A useful introduction to the interview was to discuss any points from the questionnaire. Most practitioners and students required encouragement to talk, and were concerned if they felt that they were saying something that was either unhelpful or 'the wrong thing'. To counteract this, respondents were assured that the interview was a journey of enquiry with them and that everything that they said was going to be of help and interest.

### Interview Responses

Arrangements to interview teachers by appointment were accomplished without difficulty. Students who were willing to be interviewed made time available by appointment, though the response varied from enthusiasm to hesitance. Arrangements to interview midwife clinicians varied on each site and responses depended upon whether they were hospital or community staff. On all sites, only a small number of volunteers were willing to be interviewed for the study. The research was not considered of direct relevance to a midwife's central area of work, that of client care. Education was considered peripheral. Negotiating the right time, and day was different in every place, and if there was a client to see or work to be done, the interview could be delayed. Although the managers and senior staff were very willing for their staff to be interviewed, they deferred this to the more junior staff, who, though apparently interested, would find other work to do. On one of the clinical sites only 4 out of a possible 62 practitioners were interviewed owing to appointments for interview cancelled from priorities of clinical care.

The purpose of phase four was to sample selectively. Therefore, a purposive sample (Polit and Hungler, 1991) was used to confirm data and to develop concepts. This sample was drawn from those in the three groups who met the criteria for the study. This fulfilled two purposes. One was to ensure saturation of categories, that is, when no more data can

be obtained to develop the understanding of the category; to clarify gaps in the data and confirm or refute theories developed, and the second to verify the frameworks being developed in the analysis. At the end of the interview respondents were asked to compare their responses and to make comments on the emergent frameworks. This aimed to verify the theory emerging, and develop rigour in the data analysis. A summary of interviews undertaken is given in table 30.

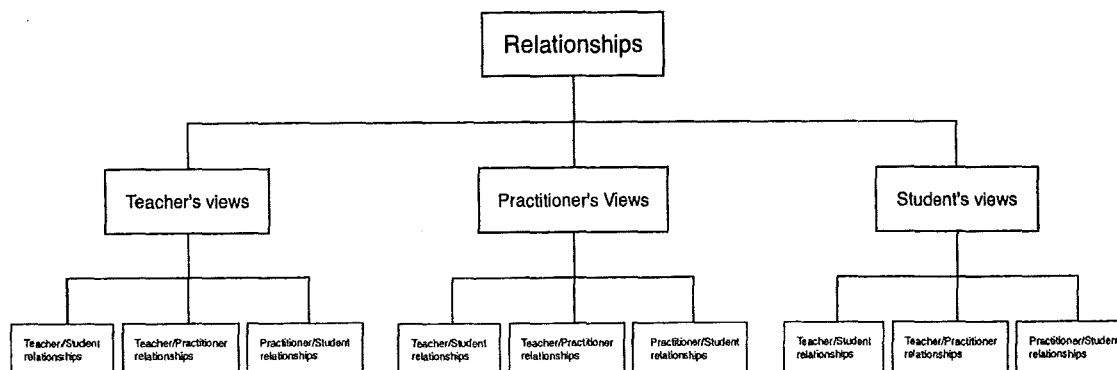
**Table 30: Summary of total interviews completed for each sample group**

Sample group	Number in each of the sample groups interviewed	Total number of interviews in each phase
Teachers	15	15
Practitioners	33	31
Students	21	19
<b>Total</b>	<b>69</b>	<b>65</b>

### **Data analysis**

Table 31. shows the three way analysis from nine perspectives of the views of the three groups. Comparing and contrasting the three different perspectives demonstrated the complexity and aimed to reduce bias in the analysis through the process of triangulation.

**Table 31: Data gathering on relationships from nine perspectives**



At each phase, the data was compared between the two methods with the analysis from the previous phase. Tapes were listened to prior to transcription and initial tapes for each sample group from each phase were transcribed by hand (Strauss and Corbin, 1990). Transcription of tapes by hand enabled notes of reflection of the interview to be annotated during the process. These notes were used for developing concepts and formed part of the data for analysis. The language on the tapes was interpreted using a personal knowledge of the terminology given by the respondents to aid development of categories for the themes, and comparison was made with the interview schedule notes (Lincoln and Guba, 1985).

Todd (1981), in his studies of socio-linguistics, states that interpretation cannot be context free, and that it is an advantage to the researcher to be aware of the language of the study in order to make an appropriate interpretation. Explanation of midwifery language was important to interpret the examples used by respondents to illustrate meanings and answers to questions. A knowledge of the technical language also aided interpretation and clarification of the meaning of the discourse on the tapes. Categories from each theme were compared to other segments of the data. Table 32. identifies the processes

involved in data analysis during the four phases though there was movement between each phase.

**Table 32: Processes in the data analysis**

Phases	The processes in the data analysis
At each phase	<ul style="list-style-type: none"> <li>• <b>Define and refine emergent categories</b> from the data of observation, questionnaires and interviews</li> <li>• Reduce codes to clusters of themes with subcategories</li> <li>• Link with data with previous phase</li> <li>• Theoretical sensitivity</li> <li>• Review of the literature</li> <li>• Revise framework</li> </ul>
Phase One	<ul style="list-style-type: none"> <li>• <b>Exploratory review of topic area</b> in the literature to develop questionnaire and interview schedule</li> </ul>
Phase two	<ul style="list-style-type: none"> <li>• <b>Formulate a framework of emergent theory</b> with literature</li> </ul>
Phase three	<ul style="list-style-type: none"> <li>• <b>Saturation of categories</b> and further refine themes</li> <li>• <b>Selectively code</b> to formulate a framework to test in next phase</li> </ul>
Phase four	<ul style="list-style-type: none"> <li>• <b>Theoretical sampling:</b> testing the framework with previous phases and with respondents</li> <li>• Redefine categories and sub-categories of both questionnaires and interviews</li> <li>• <b>Axial coding</b></li> <li>• <b>Content analysis</b> of questionnaires of final categories to link with abstraction of theory to finalise framework</li> </ul>

The data sets of questionnaires and interviews were analysed using open coding (Strauss and Corbin, 1990) or first level coding (Miles and Huberman, 1994), in an initial process of naming and categorising data. Initial coding of the three groups is given in appendices 13., 14., 15. Following analysis a number of codes emerged from the questionnaires:

- Teachers : 137 codes
- Practitioners : 128 codes
- Students : 185 codes

These codes were clustered into themes and were reduced to 14 major categories and 45 sub-categories. Table 33. summarises the reduction and merging of the coding process in this phase. Appendix 16. summarises the main emergent categories.

**Table 33: Phase 2 open coding: initial process of reduction of categories**

Coding of transcripts and questionnaires	Interview Codes	Teachers	Questionnaire codes Practitioners	Students
Open coding - total number of codes.	210	137	128	185
Reduced to major themes and sub-categories.	20 with 90 sub-categories	14 with 45 sub-categories		
Linked and merged with reformulated sub-categories of questionnaires and interviews	11 major themes with sub-categories (table 35.-page 195)			

Coding the interview transcripts of the three groups developed 210 codes. These were clustered, reduced and categorised into 20 major themes (core themes) with 90 sub-categories (appendix 17.) and linked with the questionnaires. This process was repeated in phases 2, 3 and 4.

In phase three, in linking the data, categories were refined and altered (Strauss and Corbin, 1990) with some categories saturated, that is no further new data emerged (Strauss and Corbin, 1994). At the end of this phase, data was selectively coded and preliminary definitions abstracted with emergent themes, giving the following areas of literature to be explored with analysis (table 34.).

**Table 34: The major areas of the literature to be explored**

<p><b>Professionalism and professionals</b></p> <ul style="list-style-type: none"> <li>• professional characteristics</li> <li>• knowledge and skills</li> <li>• clinical competence</li> </ul> <p><b>Education</b></p> <ul style="list-style-type: none"> <li>• learning through and with others</li> <li>• curriculum</li> <li>• the teacher's role</li> <li>• mentor/preceptor role</li> <li>• influence of practice (mother and baby) on learning</li> </ul> <p><b>Social-psychology of relationships in professions</b></p> <ul style="list-style-type: none"> <li>• social psychology of human behaviour</li> <li>• interactions in social behaviour</li> <li>• socialisation, culture, power and roles</li> <li>• group interactions and the dynamics of these on relationship formation</li> </ul> <p><b>Management and organisation</b></p> <ul style="list-style-type: none"> <li>• organisational features of curriculum planning</li> <li>• organisational issues in educational practice</li> <li>• class size</li> <li>• geographical links</li> </ul>
--

Data from questionnaires (appendix 16.) and interviews (appendix 17.) were then integrated, to form themes and sub-categories. These categories were linked with theory (Strauss and Corbin, 1990). For example, the code of 'trust' emerged in interviews and questionnaires from the three groups. This led to an exploration of theoretical

frameworks on different aspects of trust in learning relationships. This was an iterative process and a dialogical one, between the data and theoretical frameworks. The first level codes were then clustered into categories to develop core themes. The following eleven broad core themes, each with sub-categories (Strauss and Corbin, 1990) were identified at the end of this initial process (table 35.).

**Table 35: Emergent themes following coding and redefinition of categories**

<ul style="list-style-type: none"> <li>• Components of relationships</li> <li>• Nature of relationships</li> <li>• Role and relationships</li> <li>• Responsibility and accountability for students' learning</li> <li>• Communication between groups.</li> <li>• Effects of geographical separation between service and education</li> <li>• Knowledge and skills</li> <li>• Role model and mentor (the clinician role)</li> <li>• The influence of the mother, baby and family in students' learning.</li> <li>• Perceptions of relationships</li> <li>• Encounters and relationships</li> </ul>
--

These themes were used to compare and contrast with the next phase of data collection. The data informed the theory development and theoretical exploration and theory informed the data and therefore there was dialogue between the two.

Using theoretical sensitivity in the analytical process created by a knowledge of the literature, with professional and personal experience (Glaser, 1978), the codes and categories were revised to form new reduced numbers of categories and sub-categories. Sub-categories were clustered (Miles and Huberman, 1994). This was a second level coding where patterns and links were explored (Miles and Huberman, 1994). This

coding resulted from examining the meaning of the data and categorising according to the interpretation of meaning (Krippendorff, 1980; Miles and Huberman, 1994).

A further stage of axial coding, described as a process that links concepts with constructs and categories, and reconfigures the data (Strauss, 1987; Strauss and Corbin, 1990), enabled the framework to be subsequently tested. For example, in the sub-category of 'encounter', curriculum meetings will form part of encounters between each of the groups. Axial coding assisted constructs to be formed between the major categories and for the data to be reconfigured. This was followed by a stage of abstracting definitions and selectively coding each category. Data were then re-categorised with selective coding (Strauss and Corbin, 1990). Each item coded has a dimension with its own property with two opposing spectrum towards each end of a pole (Strauss and Corbin, 1990). For example, the category of 'encounter' has opposing ends of meeting.

-- meeting frequently ----- versus ----- not meeting -- .

The above processes of coding and categorisation were repeated at the end of phases two and three independently to ensure a rigorous comparison for the emergent theory and in phase four a final comparison was made to develop the emergent theory.

Following the fourth phase, a content analysis was completed for the 191 questionnaires using identified themes (Krippendorff, 1980), which indicates differences between groups and sites. This quantified the data through the meanings of the data previously categorised (Glaser and Strauss, 1967). Each phrase on the questionnaires was coded into a category that linked with the clustering of analysis of the interview data. The frequency of responses in each cluster of categories is shown in appendix 19. Use of content analysis gives weight to the categories emerging through unitising the data and applying a numerical value (Krippendorff, 1980). This was through use of descriptive statistics.



## Developing a theory

Analysis occurred at each stage of the process to review the categorisation. Categories were reviewed for overlap and relationships (Lincoln and Guba, 1985) using an interpretative approach (Cohen and Manion, 1994). The empirical work also informed the theoretical review and provided the basis for integrating and interpreting the analysis of relationships within the context of midwifery education.

Themes were cross referenced between the three sample groups at each phase (Polit and Hungler, 1991). The emerging patterns from these themes provided a basis for final categorisation and coding. Each segment of the text of the interview transcripts were coded for reference (Tesch, 1990). A method of cutting and pasting was used (Riley, 1990). The processes in the conceptual development are shown in table 36.

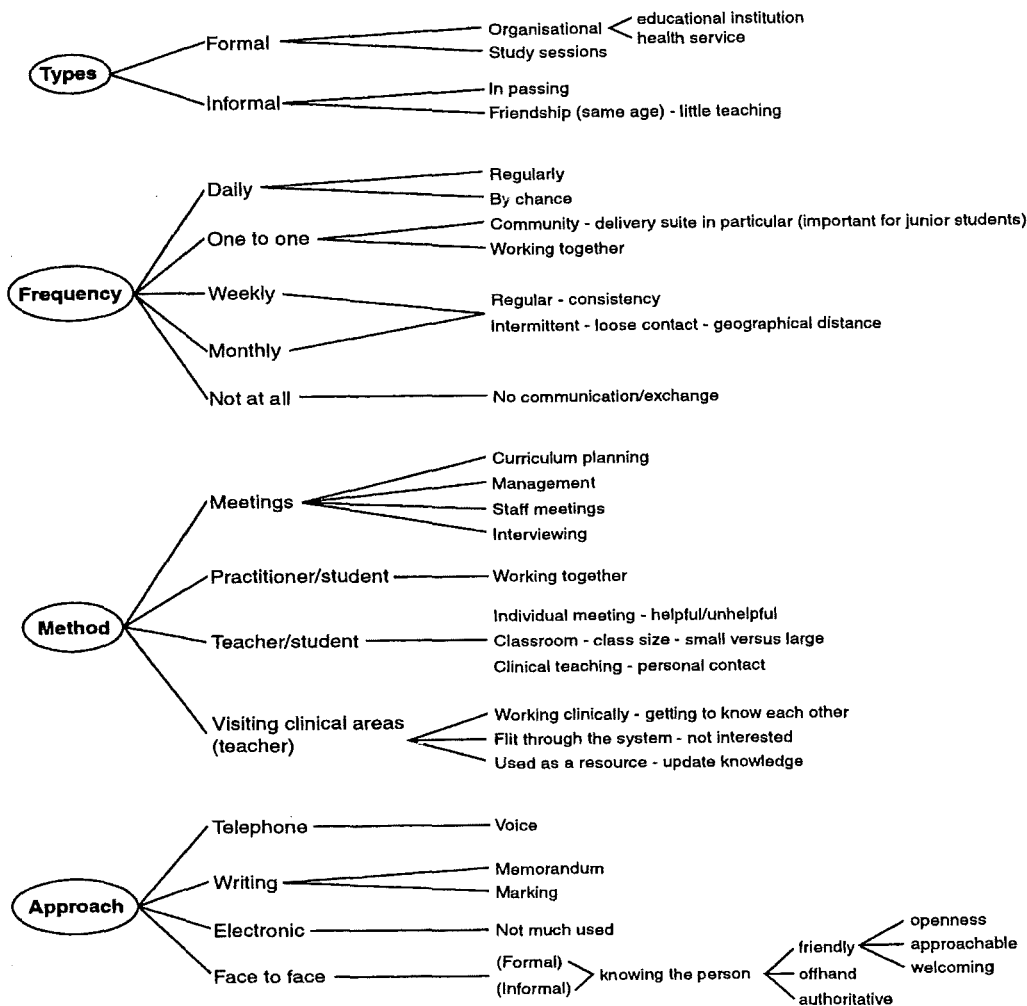
**Table 36: Conceptual development**

Phases	Theory development
<ul style="list-style-type: none"><li>• Phase One</li></ul>	<ul style="list-style-type: none"><li>• Emergent themes for further exploration</li><li>• Review initial concepts</li></ul>
<ul style="list-style-type: none"><li>• Phase two</li></ul>	<ul style="list-style-type: none"><li>• Form initial concepts and framework to link with literature</li></ul>
<ul style="list-style-type: none"><li>• Phase three</li></ul>	<ul style="list-style-type: none"><li>• Secondary coding and categorisation</li><li>• Further review of literature with new concepts emerging</li><li>• Refine codes and categories and formulate theory</li></ul>
<ul style="list-style-type: none"><li>• Phase four</li></ul>	<ul style="list-style-type: none"><li>• Verification of data and developing theory</li><li>• Development of axial coding</li><li>• Refine framework and conceptual mapping</li><li>• Review conditional matrix</li><li>• Abstract definitions</li></ul>

A process of conceptual mapping aided further analysis (Miles and Huberman, 1994). This process of using maps and sketches of categories with sub-categories formed the development of the core categories so that links and connections could be demonstrated between each category, and linked to theoretical development. An example of a

conceptual map with the category 'encounter' is given in figure 17. An example of frequency responses is given in appendix 18.

**Figure 17: An example of a concept map of the category encounter**



A further stage of analysis is to use a framework for a conditional matrix (Strauss and Corbin, 1990). This method analyses the data from different perspectives, that is, individual, professional environment, institutional environment and national professional frameworks. Thus data are viewed from these perspectives, to track events and consequences. This adds to the description of the data (Strauss and Corbin, 1990). This was completed when all the data was analysed. Further conceptual analysis developed

links through the categories, which continued with abstraction of constructs within the data.

### **Developing rigour of the study**

To develop rigour in a qualitative research study coherence between the aims of the study, the epistemology, the ontology and the methodology (Polit and Hungler 1999) should be demonstrated. Therefore the approach used was through theories of symbolic interactionism, where the world of reality becomes known through human beings perceiving the world from their social perspective rather than gaining an insider perspective as in phenomenology or a cultural perspective as in ethnography. The approach of grounded theory, with analysis, as outlined by Strauss and Corbin (1990; 1998) uses an interactionist approach and is congruent with Blumer's theories of symbolic interactionism. This was congruent with the study aims. Blumer (1980) indicates that rigour is through honest probing, alert testing and revisiting images, thus through constant comparative analysis (Strauss and Corbin, 1990,1998). The qualitative methods of participant observation, open questionnaires and in-depth interviews were also those that enabled exploration of the social world of the teacher, practitioner and student to illuminate a theory of educational relationships. The methods also enabled checking and confirming the data in different ways to compare and contrast the emergent theory.

Issues of reliability and validity are applicable to qualitative studies. One area of validity in grounded theory is sampling where there is deliberate selection of the sample for theoretical sampling (Brink, 1991; Glaser and Strauss,1967). Therefore the study sought to select individuals who were representative of the questions being addressed, particularly in phase four. Internal validity was also achieved by credibility (Tatano Beck, 1993). Asking interview respondents to critique the emerging frameworks added credibility to the data analysis. Similarly asking colleagues and presenting work externally confirmed findings that were emerging.

External validity is concerned with the applicability of the study to other populations, and therefore its transferability to other settings (Lincoln and Guba, 1985). This study has relevance for other professionals in healthcare. Reason and Rowan (1990) propose that, in new paradigms of research, validity can be achieved by looking at issues from different perspectives and complexities and this was achieved through systematic review of the data.

Stability and consistency are terms used by Guba and Lincoln (1985) for reliability, whereas Tatano Beck (1993) uses the term auditability. A record was made throughout of decisions and the progress at each phase of the study to provide an audit trail. Rigour is also dependent upon the researcher having integrity and honesty in interpreting the data as it is presented.

## **Conclusion**

Different methods of enquiry enable complex data to be gathered. There are problems in analysing such data because of the density of the information. This has been an iterative process of movement from the data to theories, with verification of the data against each phase and theory to ensure trustworthiness of the emergent theory. Section four following, presents the analysis of the empirical data. Chapter 7 gives an analysis of educational relationships, chapter 8, presents components for building relationships and chapter 9, analyses the influences on relationships. Following abstraction of the empirical and theoretical data, section five develops a theory of construction of relationships. This type of enquiry provides a wide spectrum of complex data from which conclusions can be drawn through progressively developing, refining and testing, in order to develop a new theory.

## **7 Educational relationships**

### **Introduction**

Section four, with chapters seven, eight and nine, presents the empirical data. This chapter analyses relationships in learning. In acquiring knowledge and skills, the style and level of relationships differ according to the level of intimacy. The chapter is specifically concerned with relationships between lecturers and students; practitioners and students, and between lecturers and practitioners. It also looks at the effects of client relationships on student learning.

### **Relevance of relationships in learning**

Relationships that assist the acquisition of knowledge and skills are those that enhance students' self-esteem in their own ability and that promote motivation (Abouserie 1995). An examination of teachers', practitioners' and students' relationships with each other offers an insight into the importance of the contextual issues in learning practice. The following quotations from the data emphasise the significance of harmonious relationships. The first indicates the importance of relationships between midwives and students in understanding the intimate nature of practice. Midwife 3 refers to 'a relationship' meaning one where there is a perception of exchange:

'I think that you need to have a relationship [between midwife and student]. The whole thing is such an intimate process anyway. The intimacy and closeness of midwifery means that it is set apart from other things and relationships are a lot more important. You need to know each other to work effectively. There has to be some knowledge of each other.'

Midwife 3: 12 years

This midwife identifies issues which are explored in the following pages. These are: the relationship with the mother and baby; the nature of learning intimate areas of practice; and midwifery knowledge. A second quotation relates to the importance of relationships in building students' confidence in acquiring skills:

'Relationships are necessary to convey skills. You must allow her [the student] to learn and gain confidence.'

Midwife 5: 2 years

A third quotation, in reiterating the above views, offers the notion that a close relationship provides a foundation for a student to acquire intimate skills.

'You do need a close relationship to pick up skills especially intimate skills.'

Midwife 7: 2 years

Students find relationships can provide a constructive learning context when they work with midwives on an individual basis. This type of placement, with an allocation of students to one midwife, is synonymous with a professional coach function (Schon, 1991a). Schon compares a coach function to past traditions of working as an apprentice but with a 'follow me' style where the professional assists students in reflection and promoting interaction (Schon 1991a:295-298). The relationship of the midwifery student is one where the professional anticipates tasks that students require, as in the coach function:

'Even my community midwife is really helpful. She knows exactly what I have done and says - do you want to do this? It's quite different on the labour ward. They [the labour ward midwives] do not always know.'

Student 1: 8 months

A student is more likely to stand in an apprenticeship relationship to a midwife within a community placement or in the labour ward, when the coach function can be demonstrated.

## **Relationships between professionals, women and students**

Working with women in childbirth has a direct impact on students' learning. Midwife 3 emphasises the importance of students working with clients:

[the experience of working with] 'The mother is essential to learning to be a midwife.'

Midwife 3: 12 years

The experience of being with the mother provides the essence of midwifery for a student:

'Your experience is being with her [a mother]. Although you can't experience the same thing, you're there with her.'

Student 3: 14 months

Relationships between midwife, woman and student are in a state of ebb and flow, dependent upon the clinical situation and a dynamic of exchange of knowledge, communication and social skills.

## **Learning through interaction with mother and baby**

The student draws upon her previous personal and professional knowledge and, using her experience and theories when observing the midwife, is able to apply these to a given situation. These processes of interaction differ according to each woman, midwife and student. When a student is involved in an interaction in practice, there is an active process in her learning. In each situation, a student develops her own frame of reference. Students meet a variety of situations and develop personal frameworks, upon which they

are able to draw on subsequent occasions. A framework arises when a student conceptualises experiences in practice. When a student is part of an interaction in clinical work, theory and practice can be interrelated, formed from previous experiences. Thus, with each new interaction, former frameworks for each situation are clarified and reconceptualised.

From their interactions with different midwives and families, students solidify their theories and use these in practice. Each repeated experience with accompanying exchanges between professional and student stimulates 'the form of reciprocal reflection-in-action' (Schon 1991a:163). This experience is repeated in a variety of forms. Each repeated experience adds to the student's repertoire and builds the framework for subsequent situations. Each one may require a different relationship.

'I mean we have got very different relationships with a lot of different practitioners.'

Student 17: 24 months

A student observes a midwife's interaction with a woman, the form of language and the communication exchanged. The special relationship between midwife and women and the personal qualities of the midwife are essential in creating relationship with women (Fraser, 1999). The personal qualities are conveyed through the interactions of each person, one with the other. When students are involved within the process, communication becomes interactive with both the woman and midwife. Students find that some women relate only to the midwife because of the midwife's innate authority. This is a professional characteristic (Peters 1963), particularly that of education. In situations, where the authority of the midwife is apparent, students become observers of the midwife's relationship with the woman. This next student explained that, through verbal and non-verbal communication, the midwife's authority dominated and she, the student, was excluded which, she felt, stifled her opportunity to learn:



‘Yes, it does affect me in my learning. If the mother has a question, the midwife will answer it, even though I could, and I do not learn to express myself. If the woman had looked at me I would have answered her - but if she looks at the midwife, the midwife answers her.’

Student 9: 14 months

In a situation where the midwife assumes the authority, a student takes a passive role in the relationship and passively learns from the midwife. This can be compared to Jarvis’ (1987) description of a non-reflective learning response. This is not necessarily a position which all students find difficult. Some find this helpful, particularly at the beginning of their learning programme, when there are many new experiences to absorb. More experienced students find that when a midwife takes the authority it inhibits their development, which results in their not thinking for themselves.

Experienced students who are able to undertake practice without a midwife present, or with minimal supervision are able to develop their own relationships with women. Their learning is stimulated. The student below demonstrates:

‘When you are in the community and on your own it is really good - as you answer her [the mother] and if you don't know, you can find out. You answer her and you learn.’

Student 9: 14 months

Responses of the mother are influential in students’ own perceptions of their learning.

‘The client does affect you. If the client complains about you, you have negative feedback. If the client is positive, it is really good.’

Student 3: 14 months

This is a ‘personal knowing’ where the subjectivity of a nurse’s self meets the subjectivity of the client (Liaschenko 1997:34). In midwifery, a ‘personal knowing’ will influence the student’s confidence in learning. The presence of the mother in varied situations offers students different types of experiences and provides challenges for developing sensitivity to women:

'If you are teaching a student in the classroom and you haven't got the mother to consider, you can be much more forthright when the mother is not there. For example, if you are talking about fetal heart rates - if the mother isn't there - you can talk about abnormal traces. If she was there you would have to be a lot more careful, as she would be thinking about her baby.'

Midwife 3: 12 years

Learning that takes place out of the range of the mother, therefore, can be a type of active learning (Jarvis 1992), whilst another type of active learning can be with the mother or her family present.

### **Midwives' and students' confidence and relationships**

When a midwife recognises that the student is a person who can provide care and involves the student by encouraging her thoughts and opinions, a student gains confidence. A corollary is that the mother and family will also recognise the student's expertise. A student is then confident to learn new skills and knowledge, to ask questions and to develop her own practice. In contrast, a lack of self-confidence in a midwife can be a negative force in students' learning.

'Sometimes a midwife lacks confidence which can have an effect on students - that is, a lack of confidence in a midwife's own relationships, particularly in difficult situations. When the midwife lacks her own confidence, she will not take the student with her, for example, in a delivery with a stillbirth or discussing an abnormality. I know you need great sensitivity, but all students have to learn all midwifery skills. Some midwives won't let students learn because they are unsure, and afraid that the situation may go out of control.'

Teacher 3: 4 years.

A midwife who is confident in her own practice and confident with the student can demonstrate an approach which recognises the student as a junior partner.

‘If the students see a midwife doing a positive job this will influence the student.’

Midwife 12: 4 years

A midwife who lacks confidence in practice will, in the presence of a woman, create a situation for a non-learning response in the student (Jarvis 1987).

### **The midwife/client bond and student learning**

Students fail to achieve maximum learning from situations when the midwife has a dominant relationship, or a relationship of dependence over a woman demonstrated by either the midwife or the woman. The strength of the relationship may not be stated, but can be demonstrated through non-verbal responses. The student becomes an observer and does not feel involved. She may undertake tasks for the woman but is a passive participant. In these situations, students do not feel involved, but undertake practices passively. This type of passivity in learning corresponds to Jarvis’ (1987) description of rejection in a non-learning response.

Midwives who build up a bond with the mother and family sometimes find it difficult to allow another person into relationship with their clients. Not all midwives liked having a student with them, as the student interferes with this bond. This can produce a conflict for the student or relegate her to a position of passivity. The potential conflict can be overcome. If a midwife recognises her own relationship with clients, she can offer explanations to the student of anticipated care and possible client reactions before meeting with the mother. The ability to provide explanations is dependent upon a midwife’s self-awareness of her commitment to her client relationship (Liaschenko 1997).

## Centrality of mother and baby for student learning

The role of the client in student learning is central and a 'personal knowing' of the individuals involved will influence the kind of midwifery that is practised. These findings are similar in nursing (Liaschenko 1997). This 'personal knowing' is brought about by interactions between professionals and clients and is an active process. The following quotation demonstrates the interrelationship (between student and mother) and its subjectivity:

'It's a very personal relationship; being with the mother you obtain skills through the midwife and the mum needs to relate to you and trust you. She really needs you.'

Student 8: 14 months

The student's involvement in the care of the woman aids learning but this process is also dependent upon the student /midwife relationship and the woman and midwife relationship.

The student refers to obtaining skills 'through the midwife' to indicate that the role of the midwife is to bridge the gap between herself (the student) and the mother and create a climate in which to learn. Thus, the midwife has a key role in promoting the relationship between student and mother.

The relationship between midwife and student can be transparent, and so be visible in the presence of clients:

'If your relationship with the student was poor this would come across badly. This would affect the relationship. It doesn't generally become a problem, but it can be. The mother and baby influence students as they [the mother] influence the role.'

Midwife 2: 10 years

## **Learning to be a midwife through relationships**

Midwifery is a matter of being responsive to women; working with them in a partnership, recognising individuality and family relationships and performing safely. Midwives know that they have an impact on the lives of women (Leap, 2000). Students perceived that their role is working in partnership with women:

‘As a student you are with women. You are looking after women. I can't explain that. But you are looking after women. In nursing - its general. This is work with women, not necessarily for women. If you ask a woman they will remember every detail about the event. The effect on a woman can effect her for the rest of her life. I think you have influence on the experience she remembers.’

Student 4: 14 months

## **Relationships and learning the practice of midwifery**

Midwifery skills use the sensitivity of the five senses, integrating midwifery knowledge with one's personal knowledge. The personal knowing and involvement of oneself has a subjective element:

‘It's exposing yourself.’

Midwife 10: 16 years

A sense of touch and feeling is essential to making judgements and decisions following clinical assessments. Using these skills in practice such as feeling the size of an abdomen during pregnancy, or palpating a contraction, is combined with other forms of knowledge to make judgements. It is necessary to have highly developed skills of touch, which respond to information from all the senses. The student gains the knowledge to develop these skills with observation, discussion and reflection-in-action (Schon 1991a). Information is absorbed from watching and from being supervised by an experienced midwife, when carrying out a task. There is difficulty in describing this type of skill to a

student. It is using theoretical knowledge with dexterous skills within a procedure that an understanding of a complete picture occurs, such as knowing the lie, presentation and position of the fetus, following an abdominal examination of a pregnant woman.

Replication of tasks in new and different situations facilitates the integration of theories into actions (Jarvis 1987). Integration also occurs through intuitive processes (Marks-Maran 1997). The embedding of both experience and the ability to use a previous experience in another setting is described by Benner and Tanner (1987) as intuitive knowing. Carrying out tasks that rely on previous theory gained and applying these to a situation with purposeful questioning, is a reflexive process (Rolfe 1997). Where skills are analysed with knowledge of both theory and practice, new understandings can develop. This integration is summarised in four different processes:

- Replication of tasks with an interpretation of the actions on subsequent occasions;
- Use of intuition based on previous experience;
- Purposefully questioning practice as a reflexive process;
- Analysis of both theory and practice to develop new conceptual frameworks.

Practice skills are acquired through a process of:

‘observing and being part of situations themselves....’

Teacher 2: 25 years

Integration occurs through using knowledge in a situation. An experienced midwife can build on the knowledge a student has already acquired:

‘... definitely on the post natal or labour ward, you're learning knowledge and skills. For example, this morning, delivering a baby - the perineum was stretching and there was a previous third degree tear. Sister was there - she was supporting me - she was behind me. Because I had only done one episiotomy before, I knew the principles which I had been taught. She was good. I was hesitant. She let me do it and just guided me when I needed to be guided. In a labour ward situation, you have to have the guidance when you are doing things to combine the

theory with the practice. You need the experience of practice and then it comes to light.'

Student 9: 14 months

Guiding a student requires explanation of both theoretical knowledge and skills at the right time and in appropriate ways to develop the experience of the student. This is a coaching role of the practitioner (Schon 1991a). A practitioner who reflects with the students promotes reflectivity (Mezirow 1991). This is a transformative process which develops new understandings from re-conceptualising each situation.

Students felt that skilled midwives are able to weave an understanding of culture, social factors and their personality into the way in which they respond to clients and complete procedures. Students take examples from different midwives, using those that they consider sound and discarding those they view unhelpful. The student discerns in her relationships with midwives and women the qualities that she needs to acquire for practice:

'You feel the relationship quite strongly. A lot of it is there and it is in my person and it's interacting. It is something to do with being a woman. I am influencing women's lives. It's definitely about being woman. It is the art of caring for women. I am caring for women in different ways - technology, counselling, family, everything to do with the baby, and it's being able to do it properly.'

Student 3: 14 months

Learning when to encourage, when to talk and when to keep quiet; when to use touch, and become aware of ways to approach and interact with women are all acquired skills, though, as above, some students feel that 'it is in my [their] person'. These skills become patterns of behaviour. Learning may depend upon an individual student's relationships with women.

'You must be able to communicate.....It's knowing when to talk and when not to talk.'

Student 9: 14 months

There are times when learning takes place in silence. This is not necessarily a reflective silence, when personal reflection takes place, but one where silent actions are skills of responsiveness to clients and other professionals. There are times not to talk, but to listen or to sense other forms of communication. Times of silence in practice are essential. People have different time frames for responding and silence allows another person to think and speak (Tannen 1992b).

The space is also sometimes necessary for decision-making, and students learn these skills. Decision-making and making judgements are learned by students through observing their midwife colleagues. They recognise the importance of these skills:

‘You use your initiative and judgement - more than in nursing. You are totally responsible in midwifery. It’s your decision. You make the judgement. It’s your actions.’

Student 1: 8 months

These skills, learnt within relationships, are essential to the practice of midwifery.

### **Learning professional knowledge within relationships**

Acquiring knowledge of midwifery is comprehending its specific nature:

‘Midwifery is more intense [than nursing]. It is the care of the mother and baby in depth. It is anatomy and physiology, and sociology. For example, with fetal circulation, it is important that you know how it works. Knowledge is very specific.’

Student 1: 8 months.

Factual elements of subject areas such as anatomy and immunology form a basis for understanding the processes of a woman’s maternity. Professional understanding of midwifery is acquired where there is interaction in the class setting, with a sense of trust and mutual exchange, so that students have the freedom to learn at their own pace. Both teachers and students indicated that subject areas are best learnt when there is an interaction in a relationship.



Applied subject areas, such as sociology and health promotion, provide a basis for developing midwifery. Students perceive a distant relationship with a lecturer, when the subject delivered is not applied to the subject of midwifery. This may result in a lecturer only being accepted for the delivery of the subject (or may not be accepted at all). Although presented in the classroom, subjects become meaningful when they are reviewed, reflected upon and interrelated when used in practice.

In the interviews, teachers implied that relationships between teachers and students were non-responsive when theoretical principles were taught to large groups, that is, over fifteen in number. Teachers and students indicated a preference for small group teaching (under fifteen) where theoretical concepts can be discussed interactively using examples of clinical practice. Within small groups, relationships between students and teacher can be developed (Smith and Glass, 1980). Small groups can use interactive skills, when the teacher can recognise the student's responses, particularly when sensitive subjects, such as stillbirth, are being discussed. It is these sensitive subject areas that can impinge upon the student's own experience and requires teaching that is responsive to students.

Professional knowledge depends upon the integration of theoretical propositions from lectures and theories derived from practice. These are interpreted into practice experiences, as shown by the student's comments below:

'There is anatomy and physiology. It's understanding the normal and abnormal. I think you need other subjects and they are all incorporated e.g. philosophy, ethics and psychology. It is how she [the woman] presents with pain. We give support. It encompasses everything. It's talking with [the woman] - not at. They [theoretical subjects and practice] are all interlinked. From the teacher we get theoretical input but it's more how people live, what to look for, what is obvious. If you're in the environment - you're living it. In the classroom room you don't do it.'

Student 9: 14 months

When the teacher visited the clinical area, she taught small groups. In so doing she was able to apply theory to practice and encourage students to verbalise their own ideas.

### **Learning the personal nature of midwifery through relationships**

Midwifery is a professional and a personal experience that impinges upon midwives' lives, thus transforming their personal views on womanhood, or manhood, and understandings of family lives. The professional is working with women and families and having a commitment to others, which can become her own subjective experience. Midwives, as facilitators of childbirth, are present at a family event and share in and become part of a family for the duration of the event:

'It's very personal to be a midwife. It's being with the family at birth.'

Student 2: 8 months

This experience invites a midwife to become part of a major event in the lives of others.

'You are dealing with a woman and childbirth is one of the biggest events in her life.'

Midwife 9: 8 years

Being with a woman in childbirth is to become a partner with her in the process (Leap, 2000). Midwives feel that midwifery has a different personal quality from that of other professions, including nursing, though many found it difficult to explain the distinction. The following statements illustrate notions of midwifery:

'You are involved with a woman at a personal time in her life.'

Midwife 4: 25 years

'It is sharing with the family at a very intimate time.'

Midwife 5: 2 years

‘Becoming part of their life - entering in an emotional bond with someone for a short time.’

Midwife 8: 9 years

‘Intimate skills which would at other times be considered sexual abuse.’

Midwife 15: 7 years

These quotations by midwives illustrate that midwifery is more than just an integration of theory and practice, and skills for safe practice. Midwifery is personal, intimate, emotional and requires a sense of trust between midwife and woman (Kirkham, 2000b). It is a unique and close involvement with the mother and her family. It permits access to the personal lives of another family with more freedom and familiarity than normally allowed within human relationships. Normal social boundaries are broken in midwifery.

Community midwives acknowledge that midwifery forms deep and intimate personal contacts. Midwives also discussed having close relationships with the student with a personal trust that develops. A trust relationship may also be referred to by midwives as a close relationship which is important for learning:

‘If one does not form a close relationship with the student, she is excluded from learning.’

Midwife 6: 5 years

Personal trust is not achieved quickly. It is built up through daily contact with the student and by assessing her capabilities. The student works alongside the midwife and initially practises in similar ways to the midwife. The student, whilst still being supervised, formulates her own ways of working, until she becomes semi-independent with supervision. This ‘letting go’ and allowing semi-independence was often dependent on the trust relationship that had been formed between the midwife and the student.

## **Types of relationships**

All respondents discussed close relationships. When complicated clinical situations arise and if there is not a close relationship, when a student does not receive the support of the midwife, her learning experience can be negative. Similar findings were reported by Fraser (1996). This is an example of rejection of learning (Jarvis 1987) which results in negating a learning opportunity. Complicated situations can be a challenging experience, and students who are not able to form relationships of trust with the midwife may fail to receive guidance to come to terms with an experience that may affect them emotionally.

### **Relationships that promote learning**

Creating a climate of 'feedback' is viewed by students and midwives as a necessary part of education. Feedback is an active process between the educator and learner:

'The midwife gives you positive feedback - it makes you feel good.'

Student 1: 8 months

The medium for giving and receiving feedback is the relationship, which can influence both people in offering and receiving the messages. Feedback perceived negatively can cause frustration that may result in disjunction in learning or a non learning response (Jarvis 1992). Feedback positively discussed can promote learning:

'If you get negative feedback positively and positive feedback, both will give you a good relationship. It depends how it is done.'

Student 2: 8 months

Negative feedback that results in emotional distress will not aid learning. This can be referred to as an affective dissonance. Formal feedback is part of assessment, but informal feedback occurs continuously as tasks are undertaken through verbal and non-

verbal communication. This can be a repetitive action between student and professional when they respond to each other. Where there is a relationship of trust that includes feedback, the student is supported in trying out tasks.

Acquiring skills is through observing and doing:

‘Skills are learnt by doing. Exposing themselves [students]’

Midwife 1: 15 years

Exposure within this phrase means the ability to perform a task with the associated risks. Every task within midwifery has attendant risks of human interaction, as well as professional risks. An environment that reduces risks in acquiring skills is promoted through midwife and student dialogue.

‘Theoretically students acquire knowledge through observation and [observing] the midwife as well. They [the students] like the midwife who explains things as and when they are happening. We\* do a lot of that and through getting directly involved in the situation.’

Midwife 2: 10 years.

*\* this midwife was referring to herself and her current student*

‘Whereas I had a brilliant mentor and I just feel that I have come on...’

*Question: What made her brilliant?*

‘She had a really good communication role with me. Really went over things -- took time,-- you know, in supporting me. It was very, very good..... My mentor did use resources on the ward, would use midwifery texts on the ward, would get out a doll on the delivery suite. That is the type of person she was and I think it is new and fresh in your mind. It is very easy to go over it and say ‘Oh yes, of course’ and the light bulb goes on and suddenly it is crystal clear.’

Student 15: 12 months

The dialogue can be repetitive. By talking and explaining both theories and their application, the midwife, by facilitating a student ‘doing’, is acting in a coach function (Schon 1991b). The level of relationship between the two provides a facility for a dialogue with interactions. Interaction with discussion enables skill acquisition.

Appropriate levels of explanation, with clarification by the midwife, will aid the student's understanding.

'We obtain skills through a midwife - where there is a relationship - the student learns through the midwife facilitating. It's the way they teach you.'

Student 2: 8 months

A student achieves confidence with a relationship that affords opportunities to the student to undertake tasks appropriate to her ability.

'Relationships are necessary to convey skills. Well, you need to allow her to learn - not expect too much of her too soon or being impatient of her, so that she develops confidence of her own. To do so, you must to enable her to learn a little bit by trial and error.'

Midwife 4: 25 years

To learn by trial and error (Gagne 1977) requires a midwife to 'let go' and to trust the student to experiment with her own level of skills. The student practices within the ambit of a midwife's accountability. The midwife is dependent upon her estimation of the student's ability to practice. There is an investment of trust in each other for students to learn by trial and error.

### **Relationships that hinder learning**

Problems in relationships were frequently stated to result from a personality clash, however this appeared to be more a lack of enthusiasm for knowledge by practitioners or students than a result of personal differences. If a student is not considered a full member of the professional team and there is an associated lack of interest in her as an individual, she feels rejected. A consequence is a student's inability to participate, which minimizes the educational benefit. If the rejection is partially perceived, this can result in a form of non-responsiveness in learning, whereas a student who feels totally rejected will reject her

learning experience (Jarvis 1987). Not all experiences of conflict in relationships result in poor learning situations:

‘Those who are not good examples and with whom you have bad relationships, you can learn from, but you don't want to become like them. You don't want to role model yourself on them.’

Student 4: 14 months

Students can learn from examples that they consider are inept. When students perceive a midwife demonstrating inappropriate skills or practice, they will compare these with examples or theories they consider good practice. This creates disjunction from which a student, by overcoming the problem, can learn (Jarvis 1992). The student's judgement of good practice depends upon her own level of learning and the values she develops. Fraser (1996) also reported that there were learning problems for students where there is a lack of congruence between curriculum intentions and the student experience. A form of dissonance can arise between the professional and the student because of differences in expectations. Without shared discussion on the issue, this form of dissonance has the potential to cause conflict and learning does not take place.

Conflicts occur for students when midwives have different views, or do not have the same values for practice. A sense of frustration is shown by this student:

‘I found myself very confused. Whether you should do blood sugars or shouldn't do blood sugars. Every time I worked with a different midwife she had a different view, and whether I should do this or that i.e. top up baby; take blood sugar; give extra feeds. I find myself going in ever increasing circles.’

Student 9: 14 months

This frustration, caused by a lack of consistency of behaviour, is discussed in chapter 8.

This next student considered that she was being asked to undertake a practice that was not correct:

‘She was abrupt with people and a bit flustery, and this used to get me really up tight, and every time she was around me I couldn't work properly to my capacity. I thought she is going to tell me off. I am going to do something wrong. She'd say do a B.M. stick on this baby and I would say Mum's already fed this baby - she'd say do it anyway.’

Student 5: 14 months

A midwife (teacher or practitioner) who lacks contemporary knowledge has the effect of reducing the learning potential of the situation which may cause a student to feel confused, and possibly intimidated. When a student does not agree with the midwife and feels that the midwife lacks the appropriate knowledge, she has a sense of disorientation. Dialogue is likely to be limited, with a result that the student's learning is inhibited.

A barrier to developing relationships is that of time, either through a failure of a teacher or practitioner to offer time or failure on the part of the student to seek opportunities to make time for the practitioner. A lack of understanding of each other's commitment results in confidence between the two being undermined. This can emotionally disable a student causing an affective dissonance:

‘Students don't always get on with their midwife - though these are few and far between. There can be a character clash. You can be intimidated by a midwife, and when you are told that things are wrong in front of the client, it completely throws your confidence out.’

Student 3: 14 months

Students indicated that personal conflict can be overcome. The professional expertise of the practitioner or the teacher may mitigate against a personal conflict. If the teacher, or practitioner demonstrates to the student professional qualities that are considered experienced and sound in judgement, these are more significant to the student than personal characteristics. Experienced and sound judgement of the teacher or practitioner can engender trust and respect from the student. In these circumstances disjunction can enable learning.



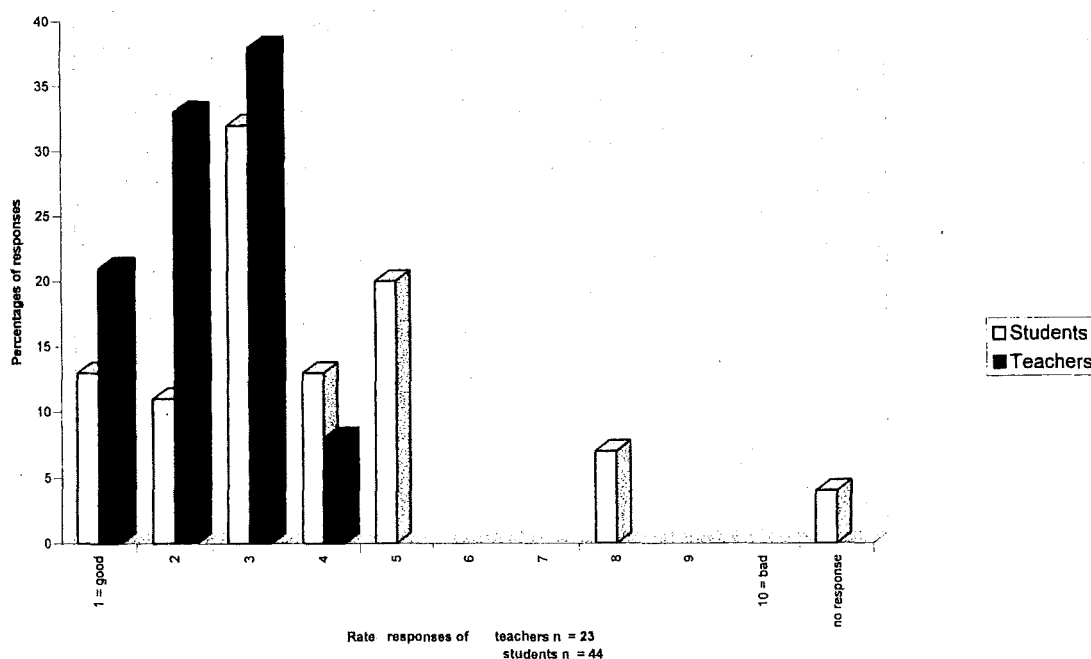
Students viewed non-conflicting relationships with practitioners as essential when undertaking skills of an intimate nature. Conflicting relationships in intimate situations create a dissonance whereas in a less intimate situation conflicts may result in disjunction in learning. Where there is a conflict of a personal nature causing a lack of trust or respect the students learning can be disabled. A lack of these qualities infers a failure of professional abilities.

## Relationships within the triad

### Teachers and students

Teachers and students rated their perceptions of their relationships with each other, shown in figure 18. Most teachers considered their relationships with students positively, and only a few students found their teachers unapproachable. The teachers' responses are more positive than those of the students. The teachers' responses reflect, perhaps, the notion that student learning is their 'raison d'être'

**Figure 18: Perceptions of relationships between teachers and students**

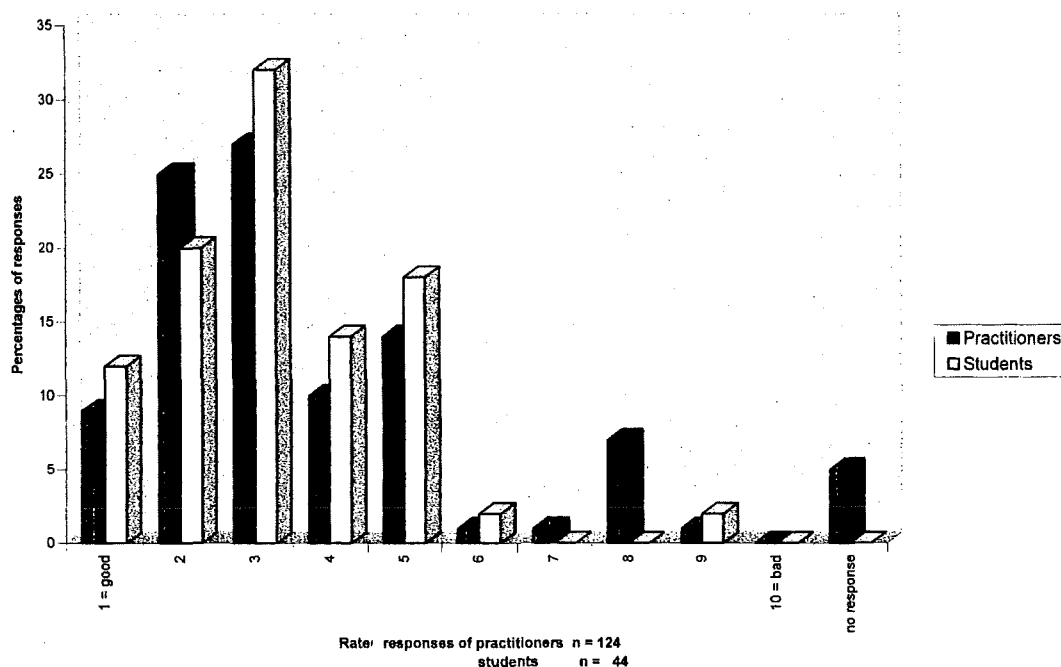


and therefore relationships with students are important to them as teachers. A student's primary focus is learning the practice of midwifery. They considered that contact was essential for assessments and the majority considered it beneficial to have close contact to assist learning. The study by Day et al (1998) also demonstrated that students value the lecturer's role in practice when contacts are made and when progression on the course is reviewed. They viewed the teacher as a facilitator for highlighting the theoretical basis to their practice and a person who would identify their ultimate needs to ensure success in the course programme. A minority of students felt that building relationships with teachers was not a necessity for learning the practice of midwifery, though Day et al (1998) indicates that most students considered communication with students in practice was necessary. Others found teachers were particularly important to them when in situations of conflict in the clinical area. Examples of conflict were differences of opinion between mentor and student, or failure of educational support from the mentor. The lecturer was also important when a student had difficulty with the theoretical aspect of the programme.

### **Practitioners and students**

Students perceived their relationships with practitioners more positively than the practitioner midwife, as can be seen in figure 19.

**Figure 19: Perceptions of relationships between practitioners and students**



This response was coloured by the relationship that the student had with her present mentor. Within some hospital units, a few students did not have an identified mentor, which contrasts with community placements. Practice is particularly important in learning midwifery. It is this area where theory can be fully embedded and its meaning realised in a student's education.

'What you see in practice and what the tutors teach is very different and somehow you [the students] have got to tease them both out and come up with your own stage if you like.'

Student 4: 14 months

It is, the student who provides a hinge between classroom knowledge and practice experience. These two student's perspectives of midwifery are defined below:

'We are doing two different things, the practical side of midwifery and the theoretical side of midwifery.'

Student 9: 14 months

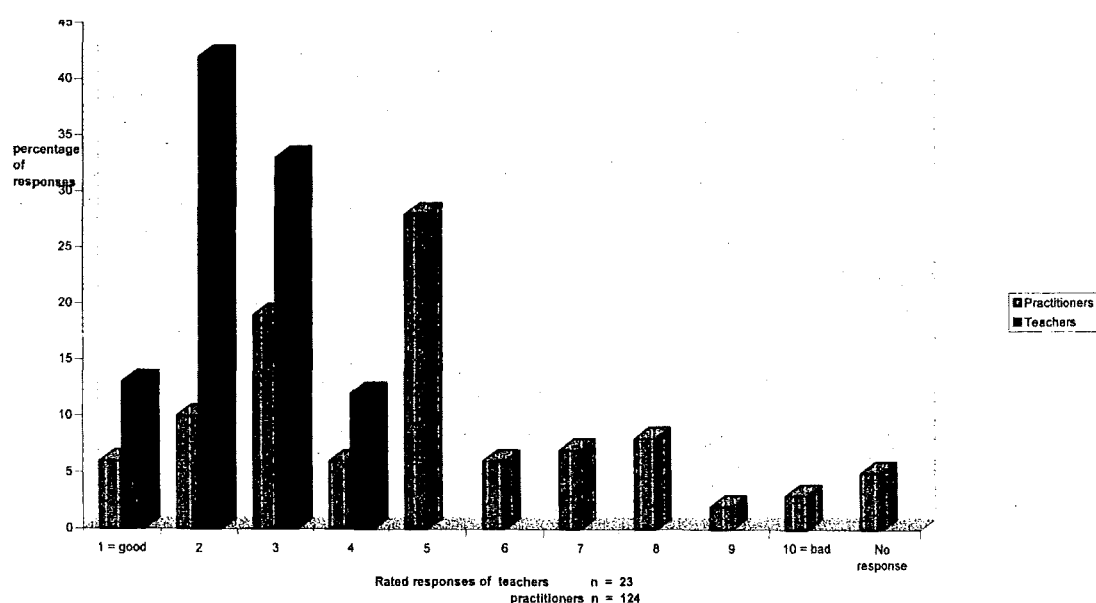
The theoretical understandings of the practitioner are important to the student, but the student will formulate her own constructions of midwifery.

Not all practitioners had responsibility for students or actively wished to take responsibility for students, and this is reflected in the lower rating given by clinical midwives in their relationships with students (figure 19). A few practitioners with low ratings did not appreciate having a responsibility for students, which indicates their lack of recognition of a pedagogical function within their role.

## Teachers and practitioners

Perceptions of relationships (figure 20) show that teachers are more positive than practitioners about their relationships with each other. Practitioners, who view teachers positively, see them as a resource for contemporary research and information. Practitioners who have continued with their professional development, or further qualifications, are more likely to have this view.

**Figure 20: Perceptions of relationships between teachers and practitioners**



Practitioners who viewed their relationships with teachers less favourably were more likely to be those who had little contact with teachers which corresponds to Day et al (1998) who found that practitioners who saw the lecturer face-to-face viewed the practice role of the lecturer more favourably. Where midwifery schools had moved out of the midwifery units, the loss of the proximity of an adjacent midwifery school, the teacher's expertise and their resources, was keenly felt.

Practitioners who stated that they do not have a close relationship with teachers see the latter as failing to keep themselves up to date with clinical practice. They perceive teachers as conveyors of theoretical information to students, which is unrealistic, or not relevant to current practice. This division in perceptions of each other's role provides a basis for the theory-practice divide. This divide is exacerbated when there is little contact between teachers and practitioners. The sentiments expressed towards teachers' clinical knowledge, as opposed to theoretical knowledge, is further endorsed by practitioners' views of the failure of teachers to agree realistic and common principles of care and to having agreed goals for practice. This antagonism may arise from a lack of exchanges of personal encounters between teachers and practitioners.

## **Summary**

This chapter has analysed relationships in practice. It has demonstrated the importance of relationships in learning professional education and the pivotal role that teachers and practitioner play in assisting the students to embed and gain knowledge. There are different forms of relationships formed between the three actors in the varied ways of acquiring knowledge.

Midwifery exposes professionals to their own emotions. The data indicated that learning the skills in intimate situations require not only a trust relationship between professional and client but also between professional and student. It is through relationships with their educators that students learn the nature of both forms of trust.

The key focus of a student's learning is the mother and her baby. The strength of relationships between mother and midwife can include or exclude the student. This will affect a student's acquisition of midwifery practice. The student and the practitioner both have a role in negotiating the right level of relationships between themselves when with the mother and family. Similarly the relationships between teachers and practitioners were seen, in the data, as important to aid both understanding the student's requirements for learning. Relationships with the teachers and practitioners form an essential medium for gaining and understanding of the knowledge and craft of practice.

Harmonious relationships between practitioner and student are particularly important when undertaking intimate and personal aspects of care. A negative relationship that creates a lack of confidence or an affective dissonance can inhibit learning. Relationships that students form can influence their process of learning and constructions of midwifery.

There are differences in relationships between the teacher, practitioner and student that depend upon the type of learning to be acquired. Relationships are also different between students and teachers in formal academic learning and the relationship with practitioners in practice. It is the student who will need to negotiate her relationships for learning with both the teachers and the practitioners but the relationship will depend upon the response she receives in return.

The role of the teacher is of importance to the practitioner in her task. Relationships with both are important to the student. The teacher and the practitioner have complementary, but different roles in student learning.

## 8 Components of Relationships

### Introduction

This chapter offers a depiction of constructs that form learning relationships in midwifery.

A summary of a thematic analysis of the open questions on the questionnaires is in appendix 19. Six types of characteristics that affect relationship building in learning emerged:

- a core component,
- a secondary component
- and four subsidiary components. These are in table 37.

**Table 37: Characteristics that individuals bring to relationship formation**

- |                                 |  |
|---------------------------------|--|
| • <b>Core component:</b>        | Personal traits  |
| • <b>Secondary component:</b>   | Social and communication abilities   |
| • <b>Subsidiary components:</b> | <ol style="list-style-type: none"><li>1. Personal knowledge;</li><li>2. Professional expertise;</li><li>3. Vision for practice;</li><li>4. Educational knowledge and skills :<ul style="list-style-type: none"><li>- Teacher</li><li>- Practitioner</li><li>- Student.</li></ul></li></ol> |

## Components of relationships: a framework

The way in which and the extent to which these components are exhibited promote or limit relationships. Each component consists of three or more elements. These are elements displayed by an individual. For example, within the component of 'personal traits' is the concept of 'respect for each other', and within the component 'educational knowledge and skills of the student', is 'eager and motivated (willingness) to learn' as illustrated by the following comment:

'The student should be willing to learn, have respect for the midwife's knowledge and skills, probably be flexible and willing to learn from everyone.'

Midwife 2: 10 years

These elements are listed within the components in table 38.

Although the chapter sets out to define and delineate characteristics that form relationships, in reality they are interwoven and present differently in varied situations. The presentation of characteristics is influenced by the dynamic impact of mother and family; or other professionals, and colleagues.

The core component, that is 'personal traits', creates an initial humour that facilitates beginnings of relationships following first and subsequent encounters. This core component creates the atmosphere for other components in relationship formation.



**Table 38: Characteristics individuals bring to relationship formation showing components and elements**

Components	Component title	Elements within the component
Core component	Personal traits	<ul style="list-style-type: none"> <li>• Respect for each other</li> <li>• Ability to trust in others</li> <li>• Personal integrity: <ul style="list-style-type: none"> <li>Being reliable</li> <li>Honesty with each other</li> <li>Consistency in behaviour</li> <li>Maintaining confidences</li> </ul> </li> <li>• Having self-confidence</li> </ul>
Secondary component	Social and communication abilities	<ul style="list-style-type: none"> <li>• Communication: <ul style="list-style-type: none"> <li>Verbal</li> <li>Non-verbal</li> <li>Ability to listen</li> </ul> </li> <li>• Social responses: <ul style="list-style-type: none"> <li>Individually</li> <li>In teamwork</li> </ul> </li> </ul>
Subsidiary components	<p><b>1. Personal knowledge</b></p> <p><b>2. Professional expertise</b></p> <p><b>3. Vision for practice</b></p> <p><b>4. Educational knowledge and skills</b></p>	<ul style="list-style-type: none"> <li>• People knowledge</li> <li>• Receptivity to others</li> <li>• Showing friendship and knowing the boundaries</li> </ul> <p><b>1. Personal knowledge</b></p> <ul style="list-style-type: none"> <li>• Knowledge of midwifery (Professional knowledge)</li> <li>• Research awareness (Scientific knowledge)</li> <li>• Knowledge in clinical practice</li> </ul> <p><b>2. Professional expertise</b></p> <ul style="list-style-type: none"> <li>• Standards for practice</li> <li>• Goals for practice</li> </ul> <p><b>3. Vision for practice</b></p> <p><u>Teacher</u></p> <ul style="list-style-type: none"> <li>• Links theory and practice</li> <li>• Uses clinical skills</li> <li>• Provides feedback</li> <li>• Teaching and education skills</li> </ul> <p><u>Practitioner</u></p> <ul style="list-style-type: none"> <li>• Teaching and education skills</li> <li>• Provides feedback</li> <li>• Knowledge of the curriculum</li> <li>• Knowledge of assessments</li> </ul> <p><u>Student</u></p> <ul style="list-style-type: none"> <li>• Recognises own learning objectives</li> <li>• Eager and motivated to learn</li> <li>• Understands and accepts the student role</li> </ul>

The elements of the core component, for example 'respect for each other', are reciprocated between people. These are reinforced or reduced at each and subsequent meetings. These create a humour, that is a disposition between people:

'There are some people you get on well with - you click with them better.  
It's almost as if they respond to you the right way.'

Student 10: 14 months

Realisation of the elements in the core component of one person by another may depend upon different situations, for example, a midwife, who normally shows respect and courtesy for students, always responding to them, may, under stress, be brusque and offhand. Realisation is the interpretation of the meaning intended and conveyed by one person to another. Realisation of another person's component will be interpreted by each person's understanding. Components that are realised can be reciprocated between people.

The core component, of personal traits, are portrayed through the medium of a secondary component of 'social and communication abilities'. The secondary component arises from individual abilities that come into play in different forms using social and communication skills dependent upon the type of encounter. The core component (personal traits) is *displayed through* this secondary component. These two components are essential as a basis to build a relationship. The secondary component is a conduit, through which the subsidiary components are reciprocated. The term conduit is used to convey the meaning of a communication channel. Reciprocation is when one person interprets the meaning of the other person and responds in exchange. The core and secondary components are displayed at all times and thus are essential in formation of relationship.

The four subsidiary components form the basis of a relationship of learning. These components are not displayed at all times but in the context of situations. These subsidiary components have elements which become evident in recurrent exchanges, and can facilitate or diminish a relationship. They are built upon with different exchanges. These subsidiary components are not evident, or even necessary, in every situation but come into play in specific events. Thus they are preferential.

Elements of one component are interlinked with elements of another component. For example, in demonstrating 'professional knowledge', the midwife uses her 'skills to teach and educate' a student, whilst the latter demonstrates 'motivation to learn' to acquire this knowledge. There are differences in the weight given by the three groups (teachers, practitioners and students) to each of the subsidiary components.

Meeting a person for the first time is part of normal learning process when meanings are interpreted by each person. At each meeting there is an initial exchange of the elements in the core and secondary component and subsequently an exchange of the elements of the subsidiary components. This may be in more than one component. In recurring encounters, a form of habitualization takes place. Jarvis (1992) describes this as a form of repetitive action that does not take place at subsequent meetings. At each subsequent meeting, exchanges are made in reciprocation to each other, which can be positive, inert or negative.

Each component has elements that are exchanged between each other and will depend upon the other's interpretation of the meaning of this exchange (Blumer, 1969). The meaning of an exchange is dependent upon an individual's understanding both from a personal and professional perspective. It is not only the psycho-social nature of meetings that provides a framework for the development of a relationship; it is also the recognition of the other person's beliefs. In educational relationships, there are certain characteristics that prevail, indicating that there are expected codes of behaviour to be adhered to within each person's role (Argyle and Henderson, 1990).

#### **Core component: personal traits**

This core component of personal traits is concerned with ethical principles that determine moral behaviour. These traits are displayed by the behaviour of an individual when one or more persons meet together.

Individual traits are not static and are reinforced through each encounter. This process of reinforcement means that once a normative form of behaviour is established, the pattern does not have to be repeated, though it can be reinforced. However, actions or behaviour perceived negatively can weaken previously held views, reducing the acceptance of one person by another. The personal traits that emerged across all the three groups are shown in table 39. below:

**Table 39: Personal traits in relationships for learning**

- Respect for each other
- Ability to trust in others
- Personal Integrity - Being reliable
  - Honesty with each other
  - Consistency in behaviour
  - Maintaining confidences
- Having self-confidence

Personal traits are demonstrated through the way in which each individual interacts with others. Portrayal of personal qualities was considered essential for the lecturer working in practice by Day et al (1998). Initial relationships are constructed through perceptions of the ways in which a person's characteristics and skills are presented, and how other person's perceive and interact in response. A positive reception of these qualities, in developing learning interactions, was also found by Fraser et al (1997,1998). An interpretation of the meaning of the action of the other person is also gained through a recognition of meanings of the language used (Jarvis, 1992).

#### Respect for each other

The concept of respect was identified by a large majority in each of the three groups. It appears to determine the quality of a relationship. Exploring this concept with each group, it became apparent that respect has differing meanings. It may mean valuing a person for

her or himself as well as her professional role. Respect is described as a moral attitude, which is just, fair, and one of non-maleficence and beneficence, recognising the individual nature of the other person (Downie and Calman, 1994). Feeling they were respected was particularly important for students who were learning:

‘They [teachers and practitioners] have to learn to respect that I am a person and not just a student, and respect the fact that I am there to learn and they are willing to teach.’

Student 3: 14 months

This type of respect included recognising a student both as a learner and an individual. The importance of recognition of the humanness of the individual in learning is discussed by Jarvis (1992). Respect between students and practitioners is shown by this student’s view:

‘I need them to recognise me for being a human being, for being an individual and also to recognise what I have done before.’

Student 6: 8 months

An associated area of respect is recognising an individual for her ideas and contributions, which resonates with Rogers’ (1983) ideas of encouraging growth in students’ learning and developing self-directedness in learning (Knowles, 1990). From a student’s point of view, she should be respected as an individual having opinions and feelings; an idiosyncratic nature and particular life experiences, and as a person who has a contribution to make whether in the classroom, higher education or in practice. If a student works alongside a midwife without her personal or professional knowledge being acknowledged, or her previous experiences being recognised, she does not feel valued for her contribution and feels unable to participate or contribute to decision making and planning:

‘We need to be acknowledged for our contribution.’

Student 7: 8 months.

Students feel part of the team when they are involved actively, and are invited to contribute and reflect their ideas, which Brookfield (1986) indicates is part of facilitation in adult learning. It is not only practitioners and teachers who offer respect to students; the students also have a responsibility to demonstrate respect for professionals:

‘Even though they [the students] may not hold the same opinions, they need to respect ours.’

Midwife 14: 10 years.

Respect is shown by any member of the three groups who accepts the point of view or opinions of the other, without being dismissive. It is also important that the credibility of one group is not dismissed by another, in the presence of the third. This was discussed particularly by students who felt that teachers and practitioners should not disregard each other and that their views should be accepted. Respect will occur when the legitimacy of the viewpoint of the other is upheld and acknowledged for its differences, rather than not accepted, with phrases as ‘out of date,’ or ‘out of touch with current practice.’ Practitioners considered that teachers should not undermine them in the presence of students, for example:

‘Telling tales of the practice area negatively.’

Midwife 8: 9 years.

Practitioners and students considered that teachers should portray positive views of practitioners. For example, suggesting to students how practitioners implement developments in practice, rather than indicating that practitioners were ignorant of new

research and developments. Likewise, students were of the view that practitioners should not dismiss the views of teachers.

### Ability to trust in others

The novice student is dependent upon both teachers and practitioners but is also, herself, a participant in the process and its result. Sharing mutual expectations is part of professional trust (Pask, 1995), with each person having a sense of trust in the other. This is both an ethical imperative, and a necessity for learning:

" You have to trust the midwife. You have to get on - you may not necessarily need to like her but you have to get on."

Student 2: 8 months

A trust relationship is one of human reliance on others. A personal trust is a foundation for personal and intimate relationships (White, 1996). Trust is brought about through mutual benefits. Trust is a form of reliance on beneficent action in the belief that a person will act in a certain way. Trust, therefore, is not cost free (White, 1996). The reliance of the student upon the professional depends upon the latter's beneficence. In this reliance, trust is, therefore, an ethical issue.

Trust is important between midwives and women in maternity care, (Kitzinger, 1988; McCrea and Crute, 1991). There are parallels between the concept of trust between educators and student and trust as a shared concept between midwives in women discussed by Stapleton et al (1998) and Kirkham (2000). It is a learned characteristic between client and professional (Hoyle and John, 1995). A trust relationship in midwifery education is



important where exchanges between learner and professional are necessarily part of social learning (Jarvis 1992; Jarvis 1997; White 1996). There is an emotional cost to both student and professional arising from a personal and professional exposure to experiences that are intimate, that would, in normal human behaviour, be excluded.

Trust is part of the social mores of learning (Jarvis, 1992; White, 1996). Forming trust with another person creates an individual boundary between what is acceptable and what is not. This also relates to social expectations of boundaries. In practice, there are accepted forms of behaviour for different tasks undertaken. In intimate actions, learning the extent of the boundaries of trust is essential in developing practice.

Without each member of the group having confidence that the other would respect the confidentiality of situations a feeling of lack of trust will prevail. Respecting confidences is an important rule in social interaction (Argyle and Henderson, 1990). Midwives and students expect that confidences for the care of clients and of their professional and personal circumstances will be maintained. Confidentiality was also considered essential by students when discussing personal issues in the classroom. It is these areas of confidentiality that can be breached.

This dialogue between two students implies concepts of confidence and confidentiality, and partnerships as elements within trust relationships:

*Student 6* "You tell them about things trusting in them"

*Student 7* "We both need to have confidence".

*Student 6* "It's discussing things you are unsure of with them and each person pulling their weight"

*Student 7* “We need equal support of midwives”

*Student 6:* 8 months

*Student 7:* 8 months

This dialogue on trust within relationships shows the importance of professionals and students recognising each person’s contribution developing a partnership whether in higher education or the health service. Where trust is developed, it provides a foundation for having confidence in each other, but will not occur unless there is a forum of encounter, or dialogue. Failure to meet expectations, inaccurate information or misunderstandings leads to a separation in the relationship. When trust relationships are impaired, they are not easily repaired (White, 1996):

‘ A negative point in past experience will affect your trust.’

*Student 9:* 14 months

Trust relates to previous knowledge. There is a strong element of reputation, that is, personal information exchanged between people about an individual that can influence other people’s trust in that person (Diego, 1988). Knowledge of the safety of behaviour of another person can underlie feelings of trust.

### Personal Integrity

There are several elements in personal integrity. a) In ethical behaviour, personal integrity engenders a commitment of one person to another. b) Integrity is complex: it is being true to one’s own values and principles and has a sense of wholeness of self, which is integrated (O’Dea, 1997). c) Integrity is an aspect of the duty of service of a professional, within the ambit of responsibility (Hoyle and John, 1995). d) There are certain rules that apply to

being a professional (Argyle, Henderson, and Furnham, 1985). These include reliability, honesty with each other, consistency in behaviour and ability to maintain confidences. Integrity includes observing the rules of a) b) c) and d) in the development of a personal and professional person.

Observing rules in forming a personal commitment is a learned behaviour. For example, professionals and students are expected to be on time for appointments, working commitments and meetings. Punctuality is an essential characteristic of a midwife's practice. Failure to be reliable results in a lack of trust. Students require patience from practitioners. Similarly students are expected to complete tasks on time. The student requires time to develop knowledge, skills and ask questions.

Observing the above rules with a personal commitment to the client is a form of professional honesty. Honesty is also being truthful and admitting when you do not know. The concept of honesty with clients and information finds expression within a professional ideal of trust (Friedson, 1994; Hoyle and John, 1995). Expectations that midwives displayed forms of honesty and reliability appeared to be of particular importance in clinical practice.

Within a commitment to others there is an expectation of consistency in behaviour:

‘You need to be told to do something and next time you do it know that you are doing it right. It is the midwife knowing what she requires, not changing her mind and giving uncertainty in her body language.’

Student 10: 14 months

To students, consistency is knowing that they are able to carry out a task, and when repeating it, know that they will not be countermanded. To midwives, consistency is knowing that students will complete tasks as expected. Consistent reactions between professionals and students underlie the concept of trust. However, when students have expectations of guidance which is unfulfilled a tension results.

### Self-confidence

A sense of confidence in oneself is demonstrated by being positive and encouraging others. This was shown by midwives who were enthusiastic and motivated in their work and by students who showed a willingness to learn as in adult learning (Knowles, 1984; Knowles, 1990). A midwife or teacher who has confidence in herself is more likely to give praise and appraise the student of her actions. Combining the two may be seen as constructive feedback, which students appreciate, and builds confidence in their practice.

### **Secondary components: social and communication abilities**

The 'social and communication abilities' are displayed by one person and reciprocated by the other, described by students and midwives as 'give and take':

'There has to be some sort of understanding...give and take... A good relationship is reciprocal. It's got to be with everyone in the ward. It's not just the students. It's got to be with everyone, including ward cleaners and doctors and other nurses and we are all interacting.'

Midwife 17: 8 years

This ‘give and take’ is an understanding, a comprehension of the meaning of an interaction and its action. Midwife 17, points to the significance of interpersonal processes with others in the health care setting. Table 40. gives an overview of the elements:

**Table 40: Secondary component: social and communication abilities**

Communication	- verbal
	- non-verbal
	- ability to listen
Social responses to others	- individually
	- in teamwork

### Communication

Communication and interpersonal skills are forms of personal knowledge (Eraut, 1994). These interpersonal qualities are important in the lecturer when working in practice (Day et al, 1998). There is an understanding of communicating with women. People do not necessarily need verbal communication as they communicate through body language (Goffman, 1963). The processes involved are those of communicating linguistically and/or symbolically that use all the senses. Students learn responses from watching and observing professionals in the clinical areas (Schon, 1991a). Knowledge of how to relate to professionals and clients, whether it is verbally, non-verbally, through touch, or with joy or

grief, is an inherent component of the midwife's role and skills. This interpersonal knowledge is significant in communicating with women on personal issues and areas of intimacy (McCrea and Crute, 1991).

Verbal communication promotes an exchange of information and was discussed by all three groups as fundamental to relationship formation and considered by Fraser et al (1997, 1998) as essential in student learning. The silent or passive midwife or student who is non-responsive towards another puts up a barrier to communication. A negative exchange creates a climate for disjunction in learning that students have to overcome (Jarvis, 1992), but it is important that a negative exchange does not diminish a student's confidence in herself, or undermine the trust of others in her. Professionals have their own ways of communicating with overt and covert discourses (Tannen, 1995). Within the phrase 'we speak the same language' there is a recognition not only of talking and listening, but also a similarity of language which is a characteristic of a community of professionals.

Non-verbal communication was referred to frequently as 'good' communication skills. This term can have different interpretations. Non-verbal communication is a matter of body language, conveying either positive and negative messages. Gestures of face, hands and body with or without verbal communication, including shorthand sounds (such as Uhuh), impart or receive information. Using gestures in communication are positive enablers in forming personal relationships, when the signs are understood by the other person. The effect of non-verbal communication is dependent upon a clear interpretation

of the messages between the sender and the receiver. Exchanges of information, in which the giver sends a clear message, and is willing in return to receive one back is seen by students as recognition of their ideas and thoughts. The interpretation of meanings of the other person is not static and will vary with each interaction (Blumer, 1969). Non-verbal messages or behaviour, particularly when these are negative, are perceived as more significant than verbal statements.

### Social responses to others

Students and practitioners indicated that a capacity for social interactions is learnt through role modelling rather than theoretical learning. The exemplar of a role model with whom a rapport is established is a powerful instrument of learning.

Social abilities include accommodating in working within a team and developing skills of negotiation, setting ground rules and recognising each other's contribution. These findings are congruent with Fraser et al (1997, 1998). This utilises both personal and process knowledge (Eraut, 1994). A lack of understanding of each other's roles with unrealistic expectations of each other's job leads to conflict between individuals. This contributes to a breakdown in relationships. Whilst process and personal knowledge are used in responding to others, there is a process of socialising the student to the culture of midwifery. Learning the coded patterns of behaviour of the profession enjoins a personal

knowledge of social and communicative patterns and enables the student to respond and contribute to the midwifery profession.

### **Subsidiary components in relationship formation**

Table 41. lists the subsidiary components discussed below:

**Table 41: Subsidiary components in relationship building**

- |   |
|---|
| <ul style="list-style-type: none"><li>• Personal knowledge</li><li>• Professional expertise</li><li>• Vision for practice</li><li>• Educational knowledge and skills:<ul style="list-style-type: none"><li>- the teacher</li><li>- the practitioner</li><li>- the student</li></ul></li></ul> |
|---|

### **Personal Knowledge**

Interaction between any two people provides a foundation for personal exchange (Jarvis, 1997). Table 42. sets out the elements within the component of personal knowledge.



**Table 42: Elements within personal knowledge**

- |  |
|--|
| <ul style="list-style-type: none"><li>• People knowledge</li><li>• Receptivity to others</li><li>• Showing friendship and knowing the boundaries</li></ul> |
|--|

### People knowledge

Recognition of another person's personal knowledge is important for interaction. This can be referred to as 'the knowing of the other'. 'Knowing of the other' is thus relevant to a student learning the practice of midwifery:

'You need to know each other to work effectively. There has to be some knowledge of each other. I think you need a relationship - the whole thing is such an intimate process anyway - the intimacy and closeness of midwifery means that it is set apart from other things and relationships are a lot more important.'

Midwife 3: 12 years

Where there is an intimacy of exchange between professional and student a 'knowing of the other' is relevant in midwifery relationships. This is a personal knowing that is tacit knowledge of both professional and student (Polanyi, 1958).

Oakley (1993) also refers to the knowing of women that is pertinent to maternity care. The 'knowing' of the other person is important in midwifery to understand women's requirements. A practitioner demonstrates her knowledge of people and how to interact with them when working alongside a student and in situations with clients. This

knowledge is conveyed to the student who sifts the information depending upon her trust in and respect for the midwife. The process of sifting information relies on a person's judgement relating to her experience and both her personal and professional knowledge. Sifting information is subject to the individual and her reaction to others.

### Receptivity to others

Three terms presented frequently in the data of both interviews and questionnaires were 'approachability', 'accessibility' and 'openness'. The terms were particularly used by clinical midwives and students and demonstrate cues of receptivity to other people. Within these terms are two characteristics; one is being both receptive to others and the other is being responsive to others, though each have different interpretations. The responsiveness is of a personal nature that comes from an understanding of oneself and the profession:

'I think it has to be you that has to get on well - not personally but you have to get on well so that they [the teachers and practitioners] can talk to you and you talk to them. It's being approachable so that you can talk and listen together. I feel silly, I ask the same questions over and over again, but I need to know that there is a relationship where I can go again and to get feedback.'

Student 10: 14 months

Receptivity and responsiveness are demonstrated through verbal and non-verbal cues; that is, the manner in which a professional looks, talks and listens to students. This student discusses cues, in particular, that of approachability:

‘It’s being approachable so that you can talk together, but I need to know that there is a relationship where I can go again. She needs to be approachable, but I need to be approachable to accept feedback.’

Student 10: 14 months

From the teacher’s and practitioner’s points of view, the student can reciprocate by demonstrating ‘openness’ in being responsive and alert to situations and individuals. This can be expressed as having a ‘willingness to learn’; being ‘able to learn from everyone’; and ‘to respond to you’; and showing ‘some enthusiasm and interest’. Students who talk and listen as part of an exchange develop new understandings:

‘Accessible close personal contact is important; talking and discussing - the student will pick it up.’

Midwife 1: 15 years

A personal approach by either practitioner or teacher, in demonstrating traits of ‘openness’ or ‘accessibility’, creates a relationship for students to feel accepted. Butterworth and Faugier (1992) use these terms in describing characteristics of a mentor’s role. All these qualities demand a form of interaction between two or more people, in either clinical or educational settings. Interactions are aided by an attuned and interested social behaviour, that are appropriate to the situation. Practitioners and teachers found it more difficult to relate to students who were not responsive.

### Showing friendship and knowing the boundaries

A professional/friend is identified in Fraser et al’s (1997, 1998) study of intended outcomes of midwifery programmes. Though this term may appear to conflict with ideas of a professional, Fraser et al use the term in association with midwives working in partnership

with women and their colleagues. However, they do identify that some students find difficulty in differentiating between a woman as a friend (that is a social friend) and a woman as a partner (Fraser, 2000a). Fraser et al (1997, 1998) comment on the analogies between the professional/friend with women and between assessors and students. Here, the term is associated with students and their educators who are not necessarily their assessors. A professional friendship in this study is not necessarily one where personal social exchanges take place, but one in which professional information and behaviour is exchanged between practitioner and student in a friendly way:

‘You become good friends - not to go out with socially - I could go to her with any problems.’

Student 4: 14 months

Characteristics of friendship are helpful in developing relationships. A phrase frequently used to express a quality in a relationship, which was more than formally professional, was ‘getting on well’. There is a personal sharing. This sharing extends to knowing the learning requirements of the student:

‘I got on really well with the midwife and the midwife helped well. She knew the client and explained where I was in training.’

Student 2: 8 months.

The result of this particular friendship was that the midwife helped the student to establish a relationship with the client. Showing friendship within a professional relationship is conveyed through situations encountered through communication (Eraut, 1994). The concept of the professional/friend indicated by Fraser et al (1997, 1998) is wider, in that their use of the term relates to the professional knowledge and skills of being a professional at the outcome of registration. The use of the term friendship emergent in this study is

related to developing partnerships between educators and students and partnerships between midwives with women. There are boundaries that limit friendship in professional behaviour. All three groups suggested friendship characteristics had benefits and costs. This compares with equity in relationships formed through exchange of rewards and costs (Argyle, 1983). Awareness of the boundaries of professional friendships vis-a-vis social friendships provides a platform for a partnership of learning. Relationships are easier where all groups enjoy each other and have a shared sense of humour:

‘With some people you really get on with them personally. It’s their sense of humour. I mean, you click. With some people you do, though with others you don’t. There are always people who you enjoy. You enjoy their company and they enjoy yours.’

Student 3: 14 months.

Flexibility by both the midwife and student aids adjustment to differing situations:

‘A positive attitude from the midwife, patience from the midwife, and understanding of what it is like to be in a new situation, depends on the midwife’s approach.’

Midwife 2: 10 years

The characteristic of professional friendship is an important feature in the recognition and exchange of each other’s experience.

### **Professional Expertise**

Professional expertise combines a sound knowledge of midwifery practice with knowledges of midwifery (chapter 4). Table 43. offers three key elements of professional expertise.

**Table 43: Professional expertise**

- Knowledge of midwifery ( professional knowledge)
- Research awareness ( scientific knowledge)
- Knowledge of clinical practice

Professional and scientific knowledge

Many respondents spoke of a 'good knowledge of midwifery' by which they meant a knowledge of contemporary professional and scientific understanding (chapter 5).

'As long as they have a good knowledge of midwifery - that's ideal... I need the knowledge I need - people have different ways of dealing with students and showing their knowledge.'

Student 3: 14 months

This is demonstrated by a clear comprehension of the knowledge base of midwifery. A 'good knowledge' is displayed by the practitioner using both contemporary scientific and professional knowledge and demonstrating this in practice. These qualities are also important for the teacher (Day et al, 1998).

Students expect practitioners to have a theoretical background because:

'Students can't learn all the theory in the classroom.'

Midwife 10: 16 years

As students gain theoretical knowledge in the classroom based on evidence and research, they expect practitioners to be conversant with theoretical perspectives and to show an ability to interpret this knowledge in practice.

‘They [the students] learn practical skills from the midwife.... They apply theory e.g. monitoring [fetal cardiotocographic monitoring].’

Midwife 12: 4 years

Interpretation of theories within practice derives from clinical situations that involve clients and/or practice. Interpretation is aided by discussion between midwife and student. The importance of informed dialogue is shown below:

‘I like a caring midwife ... but also who keeps up to date, and who tells me to do this and tells me why, but also has the educational background and research. If I can see their experience and they can back up their experience with knowledge...’

Student 10: 14 months

### Knowledge in clinical practice

Informed practice uses knowledge that is contemporary and integrates current theory with new developments. Knowledge in practice is both technological and operational. This knowledge is used in developing expert practice. Being knowledgeable in practice is also being informed about women’s views, offering informed choice, working in partnership and being responsive to women. This requires a midwife who is able to negotiate and

collaborate with a woman's own perception of her maternity and to use the knowledges appropriately to discern her practice.

Practice knowledge uses the above knowledges with life experiences and intuition (Benner and Tanner, 1987). Another form of intuition is instinctive:

‘Everyone has instinct and a sixth sense and this can be conveyed to the student. Part of it is giving them the confidence to go with that instinct.’

Midwife 1: 15 years.

This kind of instinctiveness has a knowingness of the situation (Polanyi, 1958), and confidence is dependent upon previous actions.

A few practitioners considered that some knowledge imparted to students in the academy is not relevant to clinical work and can conflict with practice. In educational institutions, teachers promulgate new knowledge to students. This can create a division between education and clinical practice, particularly for the practitioner who uses the traditions of her craft, and finds that there is little meeting point between the two forms of knowledge. A contemporary knowledge of practice can be gained by the teacher through working in practice (Day et al, 1998). However, the functions of the practitioner and the teacher, in integrating knowledge and practice, are distinctive, though complementary.

The teacher offers contemporary theoretical constructs and exposes students to debate and reflection. The practitioner is concerned with knowledge of a pragmatic nature associated with situations in practice, and she explores the nature of knowledge which is relevant to experiences from day to day. Both actors have a role in furthering integration of knowledge with practice, as students expect to be taught skills backed up with explanation



and discussion. They also expect that advice to be consistent. The gap, here, between theory and practice is one of a failure to recognise the different functions and nature of the experiences offered by the teachers and practitioners. Midwives would like teachers to assist them to have a contemporary knowledge:

‘The teacher needs to give us up to date knowledge.’

Midwife 3: 12 years

The statement above underlies a dependence within the profession, but a responsibility lies with the practitioner to maintain her professional and scientific knowledge for practice, based on current research and evidence.

### **Vision for practice**

Sharing beliefs, aims and goals both in professional practice and education, can reduce a potential distance between the academic and practice communities. The vision that academics and clinicians hold for midwifery influences their ideal way of practising. While there may be a common view of midwifery, in practice, both students and practitioners find that theories differ between education institutions and those in practice. There are also differences between midwives in regarding their views of how midwifery should be practised. These differences are demonstrated by an individual person’s vision of practice (Association of Radical Midwives, 1986; Bryar, 1995; Royal College of Midwives, 2000). Table 44. gives elements within component of a vision for practice.

**Table 44: Vision for practice**

- Standards for practice
- Goals for practice

All groups considered that teachers and clinicians should have similar goals for practice when educating students. Teachers and practitioners display their vision for practice through demonstration and articulation of their standards and goals for practice. However, academic learning will expose the student to different beliefs and values so as to enable the student to determine her own views. Nevertheless, in the respondent's views, a sharing of these goals in practice would enable each person towards achieving a similar standard of practice:

'I think that the lecturer and the midwife should have the same values. They need to be aiming for the same thing. By the end of their training, the student should have the same values. We all want the best for the women and we all want the best for ourselves. If the students do not see the values as the same there is conflict.'

Midwife 9: 8 years

Understanding differences between theories promulgated in the education institution and theories in practice occurs when students use a sifting process, discussed formerly, by observing, debating, listening and asking questions. The student selects her goals, using her theoretical knowledge and previous experience and applies these through active processes, particularly when undertaking intimate and sensitive skills. If aims and goals

are not conveyed to the student she may practise in her own way, which may conflict with a professional's view.

The student may reflect upon the views of the teacher which, if the teacher does not relate these to clinical practice, can conflict with observed practice in the clinical setting. The findings that a lack of understanding between teachers and practitioners is overcome when both groups work together to develop shared beliefs and goals for the care of clients and students was also found by Day et al (1998).

### **Educational knowledge and skills**

**Table 45: Educational knowledge and skills of each group**

• Teacher	- Links theory and practice
	- Uses clinical skills
	- Provides feedback
	- Teaching and education skills
• Practitioner	- Teaching and education skills
	- Provides feedback
	- Knowledge of the curriculum
	- Knowledge of assessments
• Student	- Eager and motivated to learn
	- Recognises learning objectives
	- Understands and accepts the student role

A summary of the elements for the component of 'educational knowledge and skills' is given in table 45. It will be noted that there are different elements for each group.

### The teacher

Teachers relate theory in the classroom to practical examples, though this does not in itself enable students to apply theory to the art of midwifery. Students ideally wish that teachers would work with them in the clinical area to assist them in understanding the relevance of theoretical insights. When teachers visit the clinical areas, practitioners and students wished that they, the teachers, would impart information on research and current trends in theories, a finding confirmed by Day et al (1998). Because teachers are rarely seen in the clinical areas their knowledge and skills are an untapped resource. The phrase 'teachers should not be in ivory towers.', (Midwife 12: 4 years), conveys a felt lack of contact between the two groups, but also the level of the perceived distance between them.

### The practitioner

Both midwife practitioners and students considered that it is the practitioner, not the teacher, who assists students in relating theory to practice:

'Teachers are reliant on practitioners to teach students clinical skills and apply theories. They [practitioners] are conveying applied theory e.g. FECG\* monitoring... They [students] learn the practical skills from the midwife. She shows them how to do it and then watches them do it until they are ready to do it on their own.'

Midwife 3: 12 years

\* *fetal cardiotocographic monitoring*

This is dependent on an individual midwife's interest in teaching, knowing about the student's curriculum and monitoring her progress:

'As a junior student [in the first part of the training], she [the practitioner] is more there as a teacher and giving you the knowledge and supervising you. Education is the judgement of what level of supervision and support you need.'

Student 9: 14 months.

Not all midwives are able to demonstrate these qualities. The practitioner's role in relating theory to practice is to apply relevant theory to the level of the student's knowledge and in current situations. A midwife's enjoyment and enthusiasm in imparting information assists a student in reflecting on her work, and in being analytical in her thinking. Skills such as these, demonstrated by the practitioner, are part of her educational skills but will have an individual style:

'There are a few midwives on the unit who are very good at teaching but perhaps the way they get things across to you, you may not like it, but as long as they teach it, you respect the way it is done. It may not be my ideal way but you learn something because you've learnt something.'

Student 3: 14 months

The effect of feedback to students as part of training gives a sense of achievement and aids reflection. This requires personal skills of knowing how to act and react to student's responses. This role of the practitioner is one of sensitivity, adjusting the knowledge conveyed, so that it is relevant and appropriate to the student.

### The student

The student has a responsibility to be motivated and enthusiastic and also to make her needs known. This reflects the idea of a student contributing her part towards a partnership between profession and student:

‘Feedback is very important. You need to know and to be praised for what you are doing and we need to know when we go wrong. We need to know our contribution and be recognised for it.’

Student 9: 14 months

Asking students for their ideas encourages them to develop their understanding actively promotes their reflection. This will give confidence.

### **Summary**

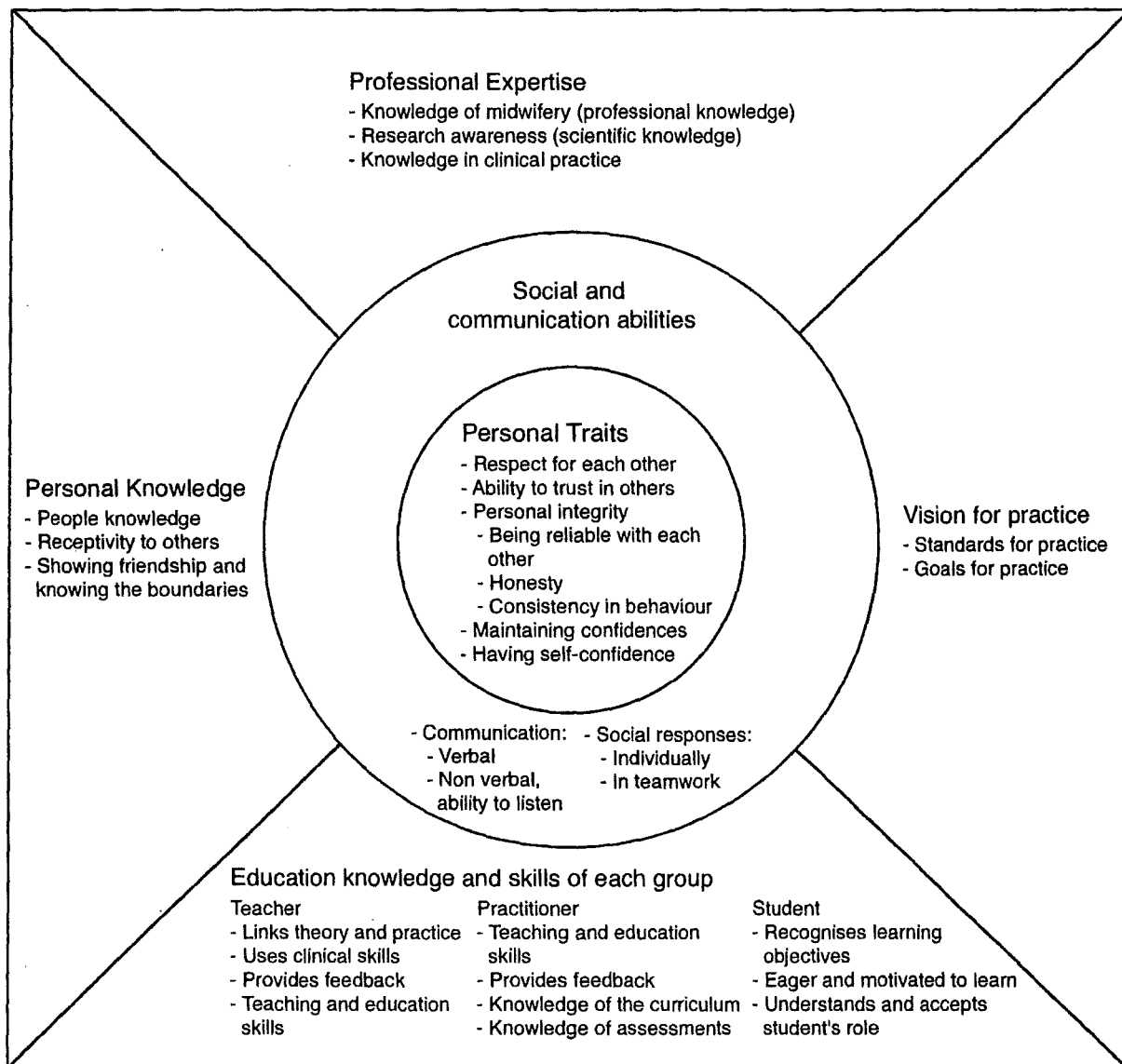
The chapter has explored the components that provide conditions for effective educational relationships. It has demonstrated features of three kinds of components in relationship formation. These are the core, the secondary and the subsidiary components. The core component comprises the personal traits of an individual that promote an initial display of disposition of one person to another. The secondary component of social and communication abilities conveys the personal traits and effects their display for interpretation by the other person. Both components are present in every interaction at each encounter. It is through these two components that the subsidiary components are conveyed from one person to another. The components are part of an individual's personal presentation and are realised by one person from another. The realisation is interpreted through each person's personal meanings and understandings.

In interactions, reciprocity and responsiveness between people are the basis for exchanges. The foundation for learning relationships are the elements in the core component, of personal traits that are conveyed through the secondary component, of social and communication abilities. These components create a climate for the conditions for interactions for the four subsidiary components; personal knowledge, professional expertise, vision for practice and educational knowledge and skills, to be exchanged.

The above six components of relationship facilitators are those which assist a student in learning new skills within the different contexts of her education. Through discussion and individual behaviour the subsidiary components are exhibited. It is through interactions of the subsidiary components that learning is stimulated. Figure 21. (page 260) gives a map of components in relationship formation, that aid constructions of relationships. Each relationship between people is individual, but the components described here promote learning relationships in midwifery. Components exhibited by each individual may be different but there may be complementarity which is an understanding of similarity between two people. .

Reciprocation of elements within a component influences the relationship and the student's acquisition of knowledge and skills. Reciprocation occurs when two people exchange elements. The components are also dependent upon the teacher's and the practitioner's personal and professional development. The next chapter considers the influences that promote or negate relationship building resulting from exchanges of these components. The student has a responsibility to stimulate others to promote her own learning. Astuteness and sensitivity are required by each person to adapt to others, with an understanding of their own ethical behaviour.

**Figure 21 Map of components in relationship formation**





## **9 Influences on relationships**

### **Introduction**

This chapter, in presenting the empirical findings, reviews influences that enhance or inhibit relationships. It is sometimes difficult to assess the catalytic processes in relationships that flourish or to assess when learning experiences fail through relationships. This chapter identifies positive and negative influences on relationships and those that promote learning. Positive and negative influences, both professional and personal, act upon the nature of a relationship between two people.

Though there are different media for making contact, such as telecommunications, video and electronic technology, face-to-face encounters that occur between teachers, practitioners and students form the basis of the present analysis. Professional influences include expectations of each group in relation to each other, for example, in matters of accountability and responsibility. There are also dimensions of control, power and authority that cannot be divorced from the professional role or the organisational context, but relate to an individual's personal influence.

### **Interactions and relationship formation**

Relationships occur through different forms of interaction. Each group identified ways in which formal and informal contacts were developed and through which interactions took

place. The formal meetings identified by the respondents are given in appendix 20. Many of these contacts were structured through arrangements between institutions of education and the health service. Where no meeting occurred between respondents they indicated that they did not have a relationship, demonstrating limited face-to-face meetings rather than their having no relationship. The various forms of meetings with face-to-face contacts are described under the concept of encounter, which range from a chance meeting to a longer formal or informal contact, that in turn can be positive or negative in effect.

All forms of meetings and contacts between teachers, practitioners and students have a potential to facilitate communication. An encounter is a medium for meaningful face-to-face exchanges. The importance of a direct encounter between one person and another is illustrated below:

"They [teacher and student] need to see each other occasionally. It is very difficult if they never meet, to feel that there is any relationship at all. To keep the channels of communication open you have, at least, to pass occasionally, even if it is in the corridor, to say that everything is fine."

Midwife 3: 12 years

This stresses the importance of repeated meetings during which communication can take place between the groups. Communication, both verbal and non verbal, provides a medium for exchanges of knowledge and interpretation of behaviour.

## **Types of encounter**

### Encounters between teacher and students.

Face-to-face encounters that take place between teachers and students are shown in appendix 20. Teachers indicated that meetings with the students in the classroom were the main form of contact but less than a quarter mentioned contact in the clinical areas. Each student was assigned a personal tutor in the academic institution, constituting a particularly important contact. In acquiring the foundations of theoretical knowledge in relation to practice, students, as novices, were reliant on a personal tutor. Students who had conflicts or difficulties in practice contacted the teacher in virtue of her personal tutor role. This function was important for students who saw the teacher as an authority, especially those who perceived that the teacher had a role in determining their success at the outcome of the programme.

Some students had difficulty in gaining access to teachers:

‘Personally my tutor - I have only seen her three times ...They are so busy.’

Student 1: 8 months

Not all students encountered these problems. However, students’ views contrast with the teacher’s perceptions. Teachers felt that they keep in close contact with the clinical areas though Day et al’s (1998) findings indicated that some teachers do not visit the clinical areas. The majority of teachers indicated that they either taught clinically or visited the clinical site regularly. On their visits, they may not come into contact with either

practitioners or students, who may be in many different clinical areas or on different shift patterns. It is only by appointment, fixed times, or visiting the wards regularly every day that a teacher will become recognised for her pattern to interact with midwives and students.

### Encounters between teachers and practitioners

Contact between teachers and practitioners was variable. Furthermore, the two groups did not share perceptions of the contacts that were made. When teachers visited the clinical sites, this was considered by some practitioners as 'a flit through the unit' so that teachers 'did not come into contact' with the activity of the ward areas. Seen by the practitioners as an avoidance of the reality of clinical work, this was, from the teacher's perspective the result of the pressures of teaching and administration, which conflicted with their wish to undertake clinical work. These pressures in work were also found by Crotty (1993), Baillie (1994) and Day et al (1998). Midwives, on a site from a midwifery school that had been moved to a distance of about ten miles away, stated:

'Teachers should be hospital based for contact.'

Midwife 12: 4 years

'There is now a lack of resources and teachers.'

Midwife 16: 1 month

Practitioner expectations were that teachers were a resource who assisted them with development of new knowledge. Teachers could also provide information on the students' curriculum a point that Day et al (1998) support in their evidence. Within this view is a notion that practitioners depend upon the teachers for their professional updating.

### Encounters between practitioners and students

All students identified the importance of working alongside practitioners for their learning. The contacts students had with their mentor in the community provided opportunities for frequent meetings. Meetings with a midwife over a complete hospital shift gave students continuous contact, particularly in the labour ward. Students were less confident in their work when they did not have close contact, or had supervision by several people over a short time span, or were supervised by someone who did not understand their educational programme. The majority of students preferred working with a midwife over a continuous period of time.

Through frequent meetings, one person develops a mutual understanding with another person.

‘The more often you work with one person the more you get to know her. If there is continuity with one midwife such as the community midwife you establish a relationship, even though you do not get on personally. You then have a working relationship with that midwife. You look forward to working with that midwife. They begin to know you and you spend so much time with that person that you get to know something about them personally, so you share something between you.’

Student 3: 14 months

A professional exchange can lead to understandings of a personal kind. Encounters can break down barriers and promote communication between individuals and groups. An encounter also provides the forum for discussion and debate, bringing forth ideas which can be shared. This exchange of professional knowledge on a regular basis reduces repetition and enhances reciprocity (Argyle 1969). The form of communication will affect

relationships. Communication and social interchange become habitualized with mutual understandings emerging which give an opportunity for sharing (Jarvis 1987):

‘Working together, talking about things and spending the whole night with the same person, looking after the same client. They [midwives] get to know what you are capable of. Now I know what I am doing, and I can talk it through with the midwife. It is having confidence in making my own decisions.’

Student 11: 14 months

Meetings provide a foundation for development of relationships. Not only are these a stimulus for students to develop their own decision-making but they are also an opportunity to discuss practice points that can personally and intimately impinge on students’ emotional well-being. Encounters or contacts between people provide a link for partnerships in learning, particularly when personal and intimate.

‘You need contact for good communication.’

Midwife 2: 10 years

There is a direct relationship between types of contacts, communication and exchanges (Argyle and Furnham 1982). A direct encounter is crucial in developing relationships between practitioners and students.

## **Professional Influences**

The previous section explored relationship formation and the influence of encounters. This next section examines professional influences; roles, accountability and responsibility, all of which are interpreted within relationships.

## **Role expectations and relationships**

Teachers, practitioners and students have their own expectations of their role in relation to clients. Roles are defined formally by agreed job designs (Handy 1985) but informally by the professional group culture. Teachers have a defined role in teaching students, but practitioners may or may not have this role defined in their job description. Therefore, education of students may not be within their formal work agreement. Students do not have a job description. Their role is defined by the curriculum and its objectives (Bruner 1966). The role of a student is implicit within a curriculum philosophy, but may not be described overtly. Roles implied within formal documentation may not be displayed in practice. This next section analyses expectations of each group of actors.

### Teacher to student : student to teacher

Teachers act as a catalyst for students to learn, to stimulate student motivation and give a sense of direction as indicated by practitioners:

‘The teacher is her [student] main source of learning and inspiration. She [teacher] needs to be her [student] supporter as well.’

Midwife 4: 25 years

‘I think she [the teacher] is there to mould and shape the student for the clinical care.’

Midwife 1: 15 years

The teacher is an activist, or as Brookfield (1986) suggests, a prompter to present alternatives in progression of a student’s education. She offers her ‘reading of the world’

that is, to bring out the fact that there are other 'readings of the world' (Freire 1994:112). This is not always comfortable for the student (Brookfield 1986). The teacher is a resource. She has a knowledge of the content and experience required within the curriculum.

Students have expectations of the teacher's role and their own role:

'It is their responsibility to teach us what we need to know. It is our responsibility to learn.'

Student 6: 14 months

For the teacher to facilitate and guide the student there needs to be contact but students have a role and responsibility to develop their own sense of direction:

'There must be a willingness on the part of the student ... She must have confidence in herself to know that what the teacher gives her is what she needs to know.'

Midwife 3: 12 years

A teacher's role is to offer insight into relevant knowledge and theories so that students have theoretical understandings for their practice.

#### Student to practitioner : practitioner to student

The practitioner midwife has an educative and facilitative role (Jarvis 1984), in assisting the student in translating theories in practical actions:

'It's my role to interpret theory and facilitate the student.'

Midwife 17: 8 years



The midwife below offers the idea that, as a role model, she uses a pragmatic approach when using theories in practice:

‘My role is more of a practical role and helping students with some of the theoretical work in relation to the practicalities of the work ... I suppose I am a role model as well.’

Midwife 2: 10 years

There is an interplay of interactions between practitioner and student that provide a stimulus for learning from primary experiences (Jarvis 1995). This idea of interaction in learning is one that Rousseau (1966) explores with a young adult learning. Both student and midwife motivate each other. The interplay produces a personal knowledge of each other:

‘The student has to be able to respond to the enthusiasm from the midwife, and the two faces of enthusiasm play off against each other. A good midwife mentor, who is enthusiastic about her job, is going to create that enthusiasm for the student, that automatically plays back again so that it becomes a mutual thing. That's important.’

Midwife 4: 25 years

The style of a relationship determines the practitioner's ability to interpret and identify the individual student's requirements:

‘If you have a good relationship you know what her needs are. You need to be able to recognise when she is happy with things and teach her practically.’

Midwife 3: 12 years

Students wanted midwives to be percipient and to approve of their actions:

‘If I need reassurance or there is an element of doubt I want to get her to discuss it, so that what I am doing is O.K. and my reasoning is sound such as - have you considered, or have you done this?’

Student 11: 14 months

This approval is one of the constructs that Fraser et al (1997, 1998) include in the term support, though the term requires more detailed extrapolation. Students also want feedback on their performance, but only appreciate it when it is constructive (Brookfield 1990) and offered with guidance so as to expand their knowledge and skills. Practitioners were of the opinion that students should be aware of the demands of work and the pressures of responsibility when working as a midwife:

‘They do not always understand the stress and strain both physically and emotionally of working - for example in caring for a mother in labour, particularly when something is prolonged or difficult. Students need to have an understanding of what the midwife is going through.’

Midwife 5: 2 years

When under stress a midwife may not respond to a student in a manner that aids a student’s comprehension. The student may not recognise the stress of a situation with a result that there is failure to understand each other, causing disharmony. The primary concerns of the midwife are for the mother, the baby and their families:

‘Learning by the student does not interfere with the care received by the client. Clients interests are paramount. Diplomacy is juggling the requirements of both.’

Midwife 9: 8 years

This centrality of the mother and baby to a midwife’s role was recognised by both midwives and students.

### Practitioner to teacher : teacher to practitioner

Teachers are aware of a responsibility towards practitioners who are mentors to students. They felt that practitioners have a responsibility to know a student's expected level of cognitive, affective and psychomotor skills:

'The practitioner's role to the teacher is to let her know if you feel you are lacking information on the curriculum and the student. The teacher has a role here and it would be helpful to know if you are on the right track. Rapport and direction is needed.'

Midwife 2: 10 years

Midwives seek direction from the teacher over curriculum issues, practical assessments and curriculum changes. Day et al (1998) suggest that this should be a role of the lecturer in practice. It is when practitioners meet with problems in student supervision that they specifically require teacher direction:

'The teacher's role is to provide feedback to practitioners of students with difficulties.'

Midwife 10: 16 years

Some practitioners felt that the students' intellectual development should be the responsibility of the teacher, but most considered that a teaching function is implicit within their role. Teachers expected practitioners to have responsibility for training students in clinical skills:

'I think they [practitioners] need to absorb responsibility for training the next generation of midwives. This is very much part of the role of the mentor.'

Teacher 6: 10 years

This view underlies the importance of student training in the clinical areas and the vital role that a practitioner has in assisting students in using theories in practice.

The majority of practitioners consider that it is the teacher who has authority for the students training. Practitioners do not recognise their own authority in determining the success of the student through their role as assessors in practice assessments. When practitioners have conflicts of opinion with the students in completing assessments, they will defer to the teacher, but it is they, themselves, who have the power and authority in this area of training. Many, however, do not have the educational background to use this power. Many practitioners rely on teachers to rescue them from conflicts with students, or poor student performance. Their perceived role of the teacher is as an authority but in contrast they, themselves, wished to remain as a 'friend' to the student.

Practitioners were ambivalent about teachers and the teacher's role in clinical practice. Whilst it was important for teachers to resolve problems, practitioners felt that because teachers were removed from the clinical areas, and with minimal contact, teachers did not understand the pressures of clinical work, a view confirmed by Day et al (1998). There was a strong feeling amongst practitioners that teachers should work in clinical practice and know the constraints:

'I feel that they should spend more time in the clinical areas.'

Midwife 7: 2 years

It was often a lack of contact that contributed to this criticism:

'It is a bit difficult. They are a bit distant.'

Midwife 9: 8 years

In spite of an expectation that teachers should work clinically, there was a degree of reservation about their ability to undertake a clinical role. On the other hand, teachers indicated a wish to be able to work in clinical practice, a finding indicated by Baillie, (1994).

### **Accountability and relationships**

Practitioners, teachers and senior students are conversant with their professional accountability (UKCC 1983,1984,1992.) and their contractual accountability to their employer (Eraut 1994). Accountability is a professional requirement (Hoyle and John 1995; Kogan, 1986). Accountability is being called to account for the standard of practice (UKCC 1996). Practitioners and students viewed accountability as a professional characteristic that requires the demonstration of set standards of clinical practice. Hoyle and John (1995) refer to this as a quality control mechanism within the profession.

Professional accountability is a characteristic of professional expertise that is learnt by the student in professional practice. It means being called to account for the care given and being legally liable for that care (Dimond 1997).

‘If I’m accountable, I can be held to blame. It holds a sense of a penalty factor.’

Midwife 3: 12 years

indicate as a type of formal professional control. Although midwives educate students, there is not a similar penalty factor in their role if they fail to be an appropriate role model or teach students less than diligently. In contrast, teachers have a professional accountability for their role as educators and the standards of education received by the students.

### Teacher accountability

Teachers are accountable for the students' progress within the curriculum; guidance on the theoretical content; students' assessments and the quality of the education process. There is a similarity here with nurse teachers' views that though they are academics they have a remit to improve practice, and this forms part of their accountability in practice (Barnett, Becher, and Cork 1987). Teachers consider their accountability is directed towards students' education which indirectly contributes to standards of clinical practice:

'I am accountable to them [the students] to ensure they have the means, to get whatever they have to do, to get their diploma.'

Teacher 2: 25 years

Students expect teachers to be accountable for their, the students' educational progress, and for their ultimate success:

'They have an accountability for teaching us and giving us what we need to learn.'

Student 5: 14 months

Within the above statement, there is a reliance upon the teacher for a certain standard of educational services. Students expected the teachers to be accountable for the standard of

education that they received. In contrast, students do not perceive they are accountable to the teacher but have a responsibility. Students perceive that they are personally accountable for their own learning:

‘No, we are not accountable to them [teachers]. I think we have responsibility to them.’

Student 10: 14 months

Teachers differentiated between practitioners' accountability for students' learning in practice and their, the teacher's accountability, for the theoretical aspects of the course programme. Thus, teachers separated learning of formal theory and the practical aspects of student training.

### Practitioner accountability

The practitioner's accountability is primarily to the client (UKCC 1983, 1984, 1992.) and students are accountable to the practitioner for their standards of care of mother and baby. Students and practitioners both recognised that the midwife's first duty of accountability is to the client and secondly to the student:

‘The midwife is more accountable to the client than us.’

Student 4: 14 months

When this was recognised by both the practitioner and student, there was congruity within their relationship. When a practitioner's accountability to the client, as a primary function, is not recognised by a student, there is a potential area of conflict. The student undertakes

practice on behalf of the practitioner and practises under the midwife's professional accountability.

Practitioners recognised that their accountability is multifaceted: to comply with the clients' wishes; to ensure safe standards of practice, and to comply with the statutory guidelines. Being accountable to one another for one's action is an unspoken contract. This is dependent upon perceptions of trust:

'Trust is a key area of accountability. On their part, they [the practitioners] need to know what you need.'

Student 5: 14 months

The midwife's accountability to the student is for student's learning. Practitioners do not consider that they are accountable to teachers for students' training. However, practitioners are accountable for students' training in practice, their intellectual growth in the profession and for the quality of a student's practice.

### Student accountability

Students felt accountable to themselves to ensure they completed the training requirements. Keenness to learn, motivation, or their contribution to others in their learning were not considered by them as influential in accountability relationships. Students are accountable to the client for their practice in accordance with their stage of training, and also in their role if they are registered nurses. Students, who are registered nurses, are acutely aware of their accountability within their professional code of practice and being answerable for their nursing practices:



‘I am accountable for myself. I am a nurse and I am accountable for my nursing skills. I am also accountable to the midwife. You may not agree with them but you are accountable to them.’

Student 7: 8 months

When there is a clash of clinical views there is conflict within students’ relationships with practitioners. Conflicts may be resolved through communication and negotiated. The student practises at the discretion of the practitioner but carries out her function to practise as a novice. There needs to exist between them a relationship of professional trust. This is because the midwife has direct client accountability for the health and welfare of mother and child. Students are accountable to the NHS for their employee function, to the midwife for their practice and to themselves for their own learning:

‘As a member of the NHS we are working and we are accountable to the midwife.’

Student 9: 14 months

A notion of accountability between practitioner and student forms an unwritten contract within their relationship. It is also a two way commitment between student and professional. Thus, the unspoken contract within the educational context engenders mutual relationships of commitment, in order to give and receive a minimum standard of service. Accountability as a professional characteristic is linked to standards of midwifery practice:

‘You are accountable for yourself and you want to achieve something. In giving good quality of care it is something that comes from within. It's not something that people can teach you unless you are motivated to do it.’

Student 9: 14 months

This characteristic within the professional midwife is an acquired attribute and part of the student’s professional development.

Both student and professional need to recognise, within their roles, the primary nature of accountability to a client, when a student is acting on behalf of the midwife. Recognising the differences between client accountability and educational accountability by educators and students is important in developing their relationships so that they understand their positions in relation to each other and to clients. The student has an accountable function in a secondary, but complementary role to the practitioner. In practice, this secondary accountability is transferred from the practitioner to the student through their relationships. Students who role model themselves on practitioners assume some of their patterns of behaviour and characteristics. This includes language, which is used to play out their professional accountability towards the clients, in which there is a moral accountability (Eraut 1994).

Some respondents differentiated between accountability and responsibility. Hoyle and John (1995) interweave the two, presenting accountability within a notion of responsibility. The respondents who described a difference between the two illustrated the following differences. Responsibility is a personal, social and purposeful code of behaviour which can be avoided, whereas accountability results from a professional code which has a penalty factor and is dependent upon professional actions and responses. The differences between accountability and responsibility as seen by midwives is illustrated by:

‘You are responsible for functions of living e.g. letting the cat out every morning. You can shirk responsibility. You cannot get away from accountability. Its always there. It is being professional. The buck stops there.’

Student 4: 14 months

## **Responsibility and relationships**

A sense of responsibility relates to behaviour which was acceptable to others, politically within their social group, and publicly, as well as to taking care of oneself. Responsibility in a relationship is personal and generates a commitment of one person to another. Responsibility has an ethical sense of being beneficent and nonmaleficent to others:

‘In the majority of circumstances most people get on - and one wants to do one’s best for them and to do no harm.’

Midwife 7: 2 years

A personal responsibility has an individual sense of social consciousness towards others. There is a certain sense of citizenship and duty to one’s neighbour within this notion of responsibility that is wider than ‘merely formal, legal and juridical terms.’ (McLaughlin 1992:236):

‘Thus the citizen must have consciousness of him or her self as a member of a living community with a shared democratic culture involving obligations and responsibilities as well as rights, as sense of common good, fraternity and so on’.

(McLaughlin 1992:236)

The notion of responsibility contains a sense of commitment, not only to the professional community, but also to the wider community. A sense of responsibility implies a personal quality, in that every person is framed by her or his own moral code of behaviour (Hoyle and John 1995). Hoyle and John (1995) suggest this sense of responsibility has similarities to Eraut’s (1994) view of moral accountability with ideas of self-commitment to others. The notion of responsibility held by respondents of this study included political and public components connected with collective commitments to others.

Responsibility was described by the respondents as an essential trait of a professional, with an indication that each professional needs to know her limits of commitments to others. This view illustrates an aspect of citizenship (McLaughlin 1992). Professional responsibility in midwifery brings these characteristics within the roles of caring for mothers and babies, to ensure their safety and well-being. It is this form of responsibility that is referred to by Fraser et al (1997, 1998) as a professional skill in decision-making in practice. The idea of responsibility by practitioners includes a sense of duty and demonstrates a morality of care to both clients and colleagues.

Professional responsibility can be developed from mutual trust (Hoyle and John 1995), respect and social rapport, but can be a state which is accepted because of status or qualification (Diego 1988). A professional relationship established in this way occurs as a result of being within the same professional group (Hoyle and John 1995). Thus, a student allocated to a midwife mentor will trust the mentor to be responsible towards her and also responsible to the woman's family.

This trust relationship engenders a responsibility because of the commitment within the professional role (Diego 1988; Hoyle and John 1995). Responsibility also includes an assumption that students will gain common and shared understandings through being educated within midwifery practice. In particular this relates to rules, regulations, policies and mutual or shared ways of behaviour. Common understandings are norms that enable relationships to be more readily established.

## Influences of power and control

Behaviour and language display notions of power and control. Power relationships were evident within the triad that is between teachers and students, practitioners and teachers, and students and practitioners.

### Power and Control

Although these two concepts are different, they are interwoven and may result in one group of people having power over another group. Power is the dominance that one person has over another. Control is the way in which a person can regulate the behaviour of another. Both concepts affect the responses that form relationships. Four forms of power are described (table 46.):

**Table 46: Forms of power in learning relationships**

Forms of power	Types of power	Effect of power on learning
Hierarchical power	A senior to junior relationship.	<b>Positive or negative learning.</b> Learning can be static.
Authoritarian power	Overt authority of one person over another putting the latter into a position of subservience.	<b>Negative with some positive learning.</b> Learning may or may not take place. Learning may be passive or learning may be inhibited.
Covert power	Covert authority which is hidden being a dominance of one person over another.	<b>Negative with no learning.</b> This is likely to result in affective dissonance (chapter 10) resulting in no learning.
Positive power	A partnership where views of the junior are upheld but the senior person takes leadership and decision roles.	<b>Positive which can result in active learning.</b>

### Hierarchical power

Problems of power in hierarchical relationships were evident from students' perspectives, particularly new students who lacked knowledge, experience and confidence in the profession. Through being in a senior position, a person holds a role of power and influence. Hierarchical power can imbue a sense of confidence in the student when appropriately used. When a senior person is dominant towards a student, the latter responds by moving into a mode of compliance that Kirkham refers to as 'doing good by stealth'(1999:736). Kirkham (1989) also notes the deference of juniors to those in senior positions in maternity services. This alters the relationship of the student with the client, for the period of that dominant presence:

'If it is a colleague [a practitioner perceived as a friend] that you work with, it doesn't make a difference, but if it is a senior person, you let them take over. You shouldn't do it, but you do. It is when the obstetricians are in the room, that it stops me from saying something. In case I should say something wrong. Whereas, if I was on my own, I would say what I thought was right.'

Student 4: 14 months

The student can perform a role of advocacy in her relationship with the client, by interceding with others on behalf of the client. Also she is able to interpret information for the woman conveyed by those in authority. Students who develop this type of role can take a responsibility for their client, but this is not possible when working with professionals who display their position in the hierarchy particularly when students work with women.

‘You'll wait until they've gone and then explain to the patient.’

Student 5: 14 months

The relationship is restored once the dominant person is not present and the student interacts directly with the client again. Hierarchical authority undermines a student's freedom to explore new ideas in learning. Hierarchical power may also be evident in the teacher student relationship in the classroom or relating to the educational programme. Students suggested that when a relationship becomes negative it stunts learning, particularly when a student realises that her questioning is not accepted. This may not necessarily be a conflict relationship. It is possibly one that is static and inhibitive in a learning process.

#### Authoritarian power

There is power in the overt authority of a professional over the student, where the latter is required to conform and accept the authority incurred, rather than to question (Peters 1963):

‘I still think there is the old school. Some treat you as if you have a certain place in the working area - You know the idea - ‘*Who does she think she is, questioning my judgement?*’ - Whereas I was asking. To enquire. To know why.

Being in the student role, whatever I said was wrong.’

Student 9: 14 months

The power here shows the overt authority of the experienced professional (Peters 1963) that requires students to conform, not question but accept, but nevertheless learning may take place. Authoritative power may be hierarchical but may be where authority is assumed through the relationship between two people where one person becomes dominant in the relationship and controls the other. This learning may be of a passive kind:

'It happened to me. A woman wanted to move around. I discussed this with the woman, and we agreed she could get off the bed. Then the midwife comes in. -*'why are you getting her off the bed?'* - She was angry. She told the woman to get onto the bed. After this, the woman did not do anything I asked her. She only responded to the midwife.'

Student 5: 14 months

Authority can be dominant in a relationship where learners are fearful of exposing themselves and feel inhibited (Freire 1966). Practitioners influence the way students work and relate to them. Students alter and change their style of working dependent upon the authority apparent within the practitioner. A demonstration of authority changes the way that students practise and this was a finding of Kirkham's (1999) in that midwives' practises alter when there is a dominant authority. A dominant authority that diminishes the self-esteem of a student or another professional can be construed as a form of bullying (Hadikin and O'Driscoll, 2000). This will affect the way in which professionals and students work together. A demonstration of authority overtly or covertly also impacts upon the students' relationships with women:

'You tend to perform at work depending upon who you are working with. Who you are working with will change your practice. You do things, the way you think they want you to practise.'

Student 4: 14 months

Where practitioner or teacher uses her authority to gain power over the students, it undermined a students' confidence. From a student's view this was a result of a lack of confidence within the professional:

'If someone such as the midwife comes in and contradicts what you're saying, it affects your relationships. It does happen in the labour ward.'



It happens with some people who cause conflict. I think they would like you to know who is in charge here. They come in to you and say something in front of the client. To me, it brings down my confidence a lot.

I say one thing to the client and then the midwife says something else. It is the ones who lack confidence in themselves and run around after you all the time. Then the client is affected.

The client always notices. They always see the relationship you have with the midwife. They see it very closely.'

Student 7: 8 months

It was also evident that the teacher could hold authoritarian power over the clinician, either by her role or by withholding information. Control of training was considered by practitioners to be the province of the education department. There was a certain resentment that practitioners were not involved or informed when changes in curriculum and training organisation took place:

'The school does not share changes in the curriculum with service.'

Midwife 6: 5 years

Lack of orientation to new developments or information about the students' curriculum was a major criticism from practitioners:

'There is a lack of orientation with assessments.'

Midwife 5: 2 years

Failure of the educationalists fully to orientate the clinical staff to new methods of education was found to disempower the practitioners and their level of confidence in

assessing students, a finding confirmed by Day et al (1998). Changes in education structures compounds the problems of lack of involvement and thus practitioners commitment to the education process.

Authoritarian relationships are not necessarily ones of conflict. Nonetheless learning can take place in an authoritarian relationship where no active interaction occurs when the student becomes a passive recipient. Passivity in a relationship, resulting from non-responsiveness of either student or educator, may be one without exchange or any action, where students conform to authority without interpretation or meaning (Peters 1963). Furthermore power and control may lead students to reject opportunities of learning (Jarvis 1987).

### Covert power

There are problems of covert power where one person becomes dominant in a relationship:

‘Well, they just get on with their job and you don’t really need to be there. They don’t notice that you are there. They just take over. You could start doing something and they will just take over. You feel you have no confidence!’

Student 12: 12 months

Covert power exerted over a person results in the other person being dominant in the relationship. In this midwife:student relationship the student’s confidence is diminished. Kirkham (2000) refers to a form blame that is acted with power over colleagues as a horizontal violence. Covert power may not necessarily be blame but it is form of power that negates the value of the other person and in this instance the student. This affects the response to learning. A reduced student confidence in her own ability can lead to frustration. It may also form a cognitive or affective dissonance. In these circumstances

the capacity to learn is reduced. Covert power may be displayed through behaviour rather than words.

A power relationship between the practitioner and student was more evident in the clinical area of the labour ward. This could be due to the stress and particular pressures of working in an institutional environment. It can also be where a student neither appreciates the particular circumstances, nor the dimensions of the role of the midwife in this practice area, nor recognises the diversity of responsibilities that practitioners encounter when making clinical decisions. Students may also not recognise that midwives do not have confidence in themselves at all times thus cause pressure on the midwife and her abilities. Violations in the norms of power by one person within relationship may have the effects of bullying upon the other person (Royal College of Midwives, 1996). Covert and overt power in a relationship can result in a student losing confidence that may mean a loss of experience essential for learning.

### Positive power

Power can be used positively and when there is mutual cooperation the relationship is enhanced: A power sharing relationship is more likely to foster learning:

‘It was someone, who at the same time was keen to teach me, that was keen when she was teaching me to sort of find out whether I was understanding - all the way along, letting me ask questions..... and then giving me sense of trust, letting me do this and even, if maybe it wasn’t always right, she would see that it wasn’t dangerous or anything, but maybe it was not the way she would do it. Instead of

suddenly correcting me in front of the client. You know, talking to me about it after or explaining it to me.'

Student 10: 14 months

In this form of power the student was respected for her views and was able to have her opinions considered. Although the professional took decisions the student felt that she was part of the process. The student was allowed to make mistakes and helped through discussion. There was an element of trust in each other. The affect of praise or personal interest inspires motivation (Kirkham, 2000). Power relationships can enhance or inhibit relationships.

## **Summary**

Each of the groups demonstrated that both professional and personal understandings influence relationships. These influences can affect relationships that enhance or inhibit learning. Explored above are both professional and personal interactions within the organisational structures. Personal face-to-face encounters are important for exchanges to take place between professional and student to promote learning. Role perception, accountability and responsibility alter the dynamics between people and influence learning relationships. Language or behaviour with power controlling actions negate learning in a relationship. Alternatively a power sharing behaviour promotes learning.

Accountability is a professional characteristic of teachers, practitioners and student and is limited to professional work associated with client, the employer, colleagues or self. There is a dual form of accountability between teachers and practitioners for students in healthcare education. Responsibility is a professional characteristic demonstrated by teachers, practitioners or students towards each other with a sense of moral self-commitment to a wider community.

Within relationships there are different levels of power. When relationships enabled a partnership between professionals and students there was opportunity for positive power relationships that enable the student to learn. Covert power undermines a student's confidence in herself and can negate learning. Both hierarchical and authoritative power can be used to effect learning but if used inappropriately with dominance and control over the student, will reduce learning.

Practitioners have a major influence on student learning in practice. The teacher facilitates theoretical learning and stimulates student's theoretical understandings to inform practice experiences. The teachers' dilemmas are their roles in clinical practice. This chapter in exploring the nature of influences on relationships in learning has outlined the importance of face-to-face encounters of teachers, practitioners and students to bring about interactions to communicate shared meanings and understandings. Influences can promote or negate the way in which relationships are effected and this, in turn, will encourage or diminish

learning. Section five, following with chapters 10 and 11, provides an analysis of literature with the empirical data to form a construction of relationships.

## **10 Constructions of relationships**

### **Introduction**

This chapter analyses contemporary educational relationships in midwifery and seeks to explain the structure of these relationships using literature and the empirical work. It also sets the scene for the development of the framework in the next chapter. The empirical data is used to explain the context and practice of relationships. Theories are mainly drawn from social psychology, in particular the work of Argyle on social interaction and Blumer (1969) on symbolic interactionism together with Jarvis' (1992) explanations of learning, though these form only part of the processes in constructions of relationships. Constraints and enablers also arise from the health service and professional culture of midwifery. A theory is offered for constructions of relationships in learning within a midwifery culture.

Initially, the notion of encounter is raised as an essential part of relationship building. An encounter occurs when exchanges take place, by chance or a planned contact, and may be hostile or harmonious. The concept of reciprocity, with give and take, is explored together with the notion of reinforcement. These processes are fundamental to the construction of relationships in active or passive learning. In this, they are framed by rules and boundaries that are crucial in training within a professional culture.

There are different levels of relationships, the levels having dynamic interrelationships. A framework is proposed that indicates movement between levels at different stages of the educational process.

## **Students and pedagogical relationships**

It is not only the students' interactions with midwives and clients that influence relationships in learning, but it is also the context and the environment in which an interaction takes place; the self-confidence of the student to deal with a particular learning situation, in that particular time and setting; and the exchanges that take place with others involved in a situation. A student, particularly one learning to be a midwife, may be exposed to life situations that raise issues for her own personal life. This can create a learning experience as situations may conflict with her own beliefs that can cause dilemmas in moral reasoning and ethical behaviour.

### **Relationships and active learning**

Praxis is a thinking and action process that integrates knowledge with practice. The result is that former knowledge in action is moved from its previous position to a new state. It is within interactive relationships that active learning is promoted. Praxis is a social activity and is part of human actions within professions (Grundy, 1989). Thus, the student learns from the interactions between herself and the midwife, but particularly from the midwife questioning her views:

'They [midwives], do sort of, double check what you do, although they [midwives] encourage you to go off and sort of take care of women on your own. They [midwives] do come back and check what you have done. They question you on why you thought - you know - whatever conclusion you come to.'

Student 15: 12 months.

Grundy suggests that praxis results from interactions between two people. Thus interactions are associated with such phenomena, for example a student and teacher discussing case notes in practice. This, she indicates, occurs as a result of an activity



in professional practice and within this professional activity the action encompasses the ethics of practice. As professional practice involves human interaction, the relationships between students and teachers or practitioners are of paramount importance in this process.

This idea is developed further by Carr and Kemmis (1993) when they place the action of praxis within the context of the practitioner: 'It is action which is considered and consciously theorized, and which may reflexively inform and transform the theory which informed it.' (Carr and Kemmis 1993:190). Thus, midwifery praxis should be an active process. In this, theories are used to determine action, and through active processes new knowledge is derived from actions. Thus, interactions between professionals and students, in transacting propositional, process, personal and interpersonal knowledge create the environment for the student to develop new knowledge.

It is in interactions between professionals and clients that the ethics of practice emerges. The ethical considerations in midwifery essentially feature through midwives' responses exhibited in their relationships between clients and other professionals:

'Someone [a midwife] who is not just interested in doing observations, that is the clinical side of it. She [the midwife] will sit down and talk to women and discuss things - allow them [women] to have their choice.'

Student 15: 12 months

Professionals and students exchange information within discourses of midwifery that give opportunity for each to share theories of practice. 'Praxis is theory and practice that are interrelated, integrated and dialectical in nature.' (Jones, 1996:126). Thus, verbal and non-verbal exchanges in a relationship between professional and student

not only create the opportunity for a student to be self-reflective, but are crucial to active learning.

### **Relationships and professional learning**

Learning is individual and does not, of necessity, depend upon a relationship with another person to activate the process. There is, nonetheless, a climate of dependence, as students model themselves on practitioners who can actively assist in processes of theory/practice integration. The nature of educational relationships is that of helping the student to acquire the culture and knowledge of a profession through both a pedagogical relationship and a socialisation process (Spiecker, 1984). There is no one kind of relationship though: the people, the professional culture, the system and the institution will all influence the socialisation process (ibid.).

A student has a sense of trust that the teacher or the clinician facilitates, supervises, educates and gives guidance on the appropriate knowledge and skills to achieve success in the course (Butterworth and Faugier, 1992). Between the professional and the student there may be a written contract. But, it is more likely that through an unwritten contract the professional will provide the climate, environment and experience for the student to learn. The unwritten contract is based upon trust. This contract is often an implicit part within relationships between professional and student but is seldom explained. The concept of trust and personal traits (chapter 8) fundamental to relationship formation for midwifery students are necessary elements in constructing professional/student relationships.

Students gain entry to a profession through modelling their own development on examples of professionals (Morton-Cooper and Palmer, 1993). They model themselves on the professionals they meet in clinical practice. The data indicated that

students' learning is positively influenced through the dynamic of relationships. They learn practices from the midwife with whom they develop a rapport, or where they recognise that the midwife demonstrates a paradigm of practice that accords with the student's view of appropriate care. Students gained their views of practice from studying; their observations in and of practice; their relationship with the teacher; and their own self development.

When a student forms a view that is critical of the practice, this offers the scope for rebelling against the norms and behaviour. Provided this does not affect the student's self-esteem (Freire, 1966) and she has confidence in herself, she is then able to reflect upon the practice and learn. She can, within a relationship, that does not diminish her self-esteem, assert her own confidence when faced with disjunction in learning.

Disjunction in learning is a cognitive state that can be affected through power relationships or when the student perceives differences between her understandings and experiences. Jarvis' (1992) argument is that disjunction is a necessary condition for learning to occur and that following disjunction, when harmony is re-established, learning will have occurred, though he also suggests that disjunction may result in rejection of learning. Therefore disjunction is a problem in a *learning process* that requires solving rather than a *conflict that contextualises learning*. The view here is that disjunction *may* promote learning, *provided* the causes of disjunction do not undermine a student's confidence in herself. In midwifery, a student learns through the medium of others and thus disjunction is not context free. Disjunction is associated with interactions between people and may possibly result in conflict.

A lack of self-esteem, promoted by words or actions that result from relationships of conflict or power, can effect a loss of self-worth, confidence and enthusiasm to learn and in turn can stem the student's ability to learn. Academic self-worth is noted by Fraser et al (1997,1998) as important in student learning. There are, in Schon's

(1991b) explanations of communication between master and student, issues of interpretation of meaning between the two people. A lack of understanding of meanings between people can also cause a sense of conflict and lowered confidence in the student. This effect of lowered self-worth has a negative influence on learning. Furthermore, Elliott suggests that in the 'complex web of affective and cognitive processes in operation...' inconsistencies in learning can create dissonance, particularly those that result from emotional responses to learning (Elliott, 1995:258). When disharmony occurs in the cognitive domain it may, through disjunction, promote or negate learning. This is provided that it does not reduce self-esteem. When disharmony occurs in the affective domain it can reduce a student's self-perceptions of worth and inhibit learning. This results in an affective dissonance. Where there is dissonance in the affective domain, that results from personal relationships and self-esteem is affected, the student stops learning. Students found the emotional effects of conflict in relationship disabling to their learning.

### **The construction of relationships**

Many midwives are of similar age to their students, as are their clients. Rizzo's (1988) study of children indicates the importance of developing friendship relationships for social acceptance:

'I know that when I was at hospital X that there was a different breed of student - sometimes *these girls* [students in present hospital] are in a totally different - in a new environment.'

Midwife 13: 20 years

Midwife 13 had a wide age difference between the students and herself and many of the students. She went on to discuss the difficulties with *these girls* [students] who neither understood her expectations of their role, nor undertook tasks as she expected; an issue that she felt made relationships with them difficult.

Being socially accepted is an important part of socialisation in becoming a member of a profession. Social acceptance depends upon shared interests, regular contact and being part of a group. This promotes mutual professional understandings that accommodate complementary and divergent personality differences. Relationships are powerfully influenced by culture (Argyle, 1992). Sharing a common culture can itself be a group expectation of conformity. This, for a student, can be a powerful influence. Professional teamwork aims towards mutual cooperation, where a moral or ethical code of behaviour is an expected group norm (Argyle, 1973; Sherif and Sherif, 1978).

### **Structuring relationships**

During a lifetime people form many different kinds of relationships, with past experiences, culture, and expectations, that influence interactions (Argyle, 1973). A relationship can be described by positive or negative adjectives and can be static or dynamic. Relationships are two-way interactions:

‘Any sort of relationship must have the ‘two way thing’. It is not just, sort of, me giving to the student - I’m getting feedback - am I doing it right? - she is not agreeing/ that sort of thing.’

Midwife 12: 4 years

Blumer (1969) suggests that an individual’s interpretation is associated with each person’s self-perception of both action and responses. He uses the term symbolic interactionism to indicate a symbolic meaning or ascription of cultural phenomena to particular ideas, that result from person to person interactions. It invokes readjusting one’s own responses to the personal interpretation of the other person and this forms part of the ‘complementarity of the expectations’ (Blumer, 1969:68) of one person for

another. Therefore, the two way relationship described by midwife 12 is dependent upon each person's interpretation of meaning and gestures in effecting a relationship.

Blumer suggests that all interactions result in an interpretation, and that each person attributes meanings to the other person's actions, gestures, conversations and responses, though this can be interpreted consciously or unconsciously. Thus, symbolic interactions are interpretive upon the actions of others with both dialogue and gestures. This process of interaction, with interpretation by each person of their own meaning forms the joint action.

Tannen, studying linguistics, indicates that the way messages are interpreted in an interaction will mould a relationship (Tannen, 1992a), with exchanges of messages of deference and solidarity (Tannen, 1990). Social relations are 'constructed in interactions' (Tannen, 1994). Responses from each individual will depend upon their own experience and frames of reference (Tannen, 1992a). Responses will demonstrate levels of understandings of meanings and gestures in the relationship between two people. In education, there are times when responses need to be activated to encourage students and their mentors to think and act as part of this interaction. Responses will depend upon the following dimensions of relationships.

### **Rules and Boundaries**

Rules and boundaries form part of the social processes of life (Spiecker, 1984). There are joint rules that apply to each person who interprets them according to their personal repertoire of experience. Rules and boundaries, framed by social systems, are acquired by students in their relationships, particularly within clinical practice. These rules are endorsed within social conventions and by societies' constructions

(Argyle and Henderson, 1990; Argyle, Henderson and Furnham, 1985; Henderson and Argyle, 1984).

### Rules

A student forms personal relationships with both professionals and clients. There are rules about behaviour with others and within different social and cultural expectations (Goffman, 1966). Failure to conform with rules gives messages of non-conformity (Goffman, 1968). Unwritten rules are learned by students when observing interactions between professionals and clients. The student observes differences in relationships between clients and professionals at various stages of pregnancy, labour and the puerperium, when practitioners respond to situations with cognitive, affective and psychomotor responses. Thus, she acquires the rules to conform to the norms of behaviour in the profession:

There are certain ways that they [students] have to behave and to some extent, I guess, midwives are wanting to mould them [students] into the way they [midwives] are themselves. So I guess, it's easier if your student conforms.'

Midwife 29: 9 years

The rules will alter dependent upon the task to be undertaken. They relate to social expectations, that is, that there is a consistency in conforming to the norms and constraints of behaviour (Goffman, 1967). Learning the professional norms and constraints is through moulding. 'Moulding' students is enabling them to recognise the rules within the profession.

Argyle (1992) indicates that rules of intimacy depend upon and differ between cultures and socialisation processes. Rules govern the boundaries applied to intimate

personal relationships (Argyle and Henderson, 1990). Except within the confines of close friendships and kinship, adults normally avoid intimate language and gestures; using endearments with meaning; close facial contact; skin touching or whole bodily contact; exposure of intimate parts of one person to another; handling, and performing intimate acts in the presence of others. These rules of intimacy are traversed in the practice of midwifery when caring for pregnant women.

Rules in relationships between teachers, practitioners and students are, in part, constructs of the social expectations of each group of the triad (Henderson and Argyle, 1984). Rules of behaviour have boundaries within professional practice, but students require knowledge of the rules for caring for women in childbirth. Altering the boundaries of social rules requires sensitivity to each woman, recognising her responses and culture. Each woman is different and when to touch, embrace or make personal contact with her will depend upon the individual circumstances between two people. Students learn the rules and boundaries and professional conventions through observing and being part of the actions. This is 'moulding' as described by midwife 29 and midwife 1 (page 267).

### Boundaries

Boundaries may be crossed. There are occasions when unpredictable situations occur, such as an sudden unexpected stillbirth, when trust and respect become important. If a trust relationship exists normal boundaries can be overstepped.

Personal and professional relationships are discrete, though the boundaries of professionalism may traverse the boundaries of friendship. Friendship relationships



are important in midwifery between professionals and between midwives and clients because of the intimate nature and human interactions (McRea and Crute, 1991; Fraser et al, 1997, 1998; Leap 2000). Similarities in gender, ages and/or interests, are common grounds for a personal relationship:

‘If you open yourself up a bit more, they [midwives] begin to form a personal relationship with you and I find that you can communicate better and have a rapport with that midwife.’

Student 15: 12 months

Relationships can be construed as personal relationships rather than professional relationships. However, personal and professional responses may be linked, particularly for a common purpose (White, 1996). Fraser et al’s (1997, 1998) concept of the professional/friend approach combines professional characteristics with personal and communication skills. Professional responses concern midwifery practice whereas personal responses concern an individual’s state such as personal interests. Personal responses with incidental conversations create a form of friendliness between people, resulting in a friendship relationship that creates partnerships.

In a friendship response, personal information of a more intimate nature can be shared depending upon the closeness of the relationship:

‘I find it quite easy to tell them [students] about myself and I think that it makes them feel comfortable.’

*Question: What sort of things do you disclose?*

Well, it is sort of things like - if you [student or midwife] have got a boyfriend or a family. Also that you have a life apart from midwifery. ...You might be able to find a common ground that you have [both] got an interest in and you can identify that they [students] have something other than midwifery to identify with them.’

Midwife 14: 10 years

This concept of self-disclosure (Argyle, 1992) in close relationships between peers is disclosing information to others to find that 'common ground' but does not extend to personal details that could be self-threatening. Going beyond the limit of personal sharing of a 'common ground' in a close friendship response is a form of self-disclosure when such topics as health, stress or intimate personal circumstances are shared. A student may seek a close friendship response when there are moments of personal crisis affecting work, or where there are situations of stress or joy at work but boundaries crossed in moments of stress may not always be crossed again. Learning the limits of boundaries and their closeness versus looseness and the confidence required to alter boundaries, lies within the learning repertoire of all three groups. In professional relationships, students learn the boundaries to be accepted within group norms (Sherif and Sherif, 1978).

Sharing of personal details, particularly between women who are not being intimate (Argyle and Henderson, 1990; Tannen, 1992b) breaks barriers between professional and student:

'One particular student - we actually got on very well. We had things in common.... She came from Australia and I had been there so we had that to start a working relationship.'

Midwife 12: 4 years

Boundaries to interests that are shared depend upon the closeness of the relationship, for example, sharing personal and professional experiences. There are normative modes of distance in social interactions (Goffman, 1961). Students are required to learn the boundaries of the norm in a profession's behaviour. Students found sharing personal information of an informal nature assisted in early relationship contacts and broke initial barriers. Communication between those who have a close bond results from an ability to recognise each other's frame of reference (Tannen, 1992a). This allows intimate gestures and a sharing of personal thoughts that are sometimes of very

personal and secret matters; this can demonstrate rapport and solidarity (Tannen, 1990).

Boundaries are broken when professionals or students behave or communicate in manners not acceptable within the professional society. For example, a midwife described a student's aggressive manner to herself and clients but she felt the student accepted this behaviour as a normal manner. Other midwives discussed relationship problems with students who failed to communicate well or who talked inappropriately in front of clients about their personal lives. Examples from students of boundaries being crossed were midwives who used endearments inappropriately or who acted with a touching response to students or with clients before they had 'got to know each other'.

In practice, students in their clinical work, with both women and clinicians form a variety of relationships for short term periods, and then let go. This requires confidence. The relationship bond, therefore, with clients and professionals, is one that needs to be forged rapidly and in most circumstances released. Midwives expect students to recognise and adapt to the alteration of the boundaries within clinical practice when caring for pregnant women.

## **Encounter and exchanges**

### Encounters

A person can have differing relationships through varied types of encounters (Argyle, 1992; Argyle, Henderson, and Furnham, 1985). Encounters can promote reciprocity, or they may occur without any interchange. This discussion is primarily concerned with the face-to-face encounter. Goffman (1963) refers to encounters through facial gestures. His view is that facial gestures promote accessibility. Goffman (1961)

further indicates that interactions in encounters are based on rules of social expectations with each person having a self-identity with the situation. Thus, encounters are the basis for structuring relationships. Blumer (1969) stresses the importance of an encounter being fundamental to any interaction or exchanges taking place. Midwife 28 indicates the relevance of dialogue taking place:

‘If the teachers come on the wards midwives can discuss with them [things], such as: ‘Well, how come you haven’t taught them this in class?’ Or if I see them I just have a chat outside.’

Midwife 28: 4 years

Dialogue will not occur between two or more people unless there is a medium for encounter. The exchange depends upon the dialogue interchanged and the nature of the meeting. Encounters may be verbal, nonverbal, tactile, written, and gained through various media. Encounters may be frequent or infrequent, static or dynamic.

Between practitioners and students, encounters take place within the milieu of clinical practice where a client is often the centre of the dialogue. A dyadic encounter between student and practitioner provides a basis for learning. However, it is in the triadic encounter between practitioners, students and the client, that students learn the activities of their practice, and where the interactions between the three may vary the interpretation. In a frequent encounter, a student can form a one-to-one relationship with a midwife:

‘Your relationship with the clinician is very close. You are learning alongside them. You are an apprentice and you are learning what life is really like.’

Student 9: 14 months

## Exchanges

Exchanges are part of the interactive process described above and enable an interpretive process (Hargreaves, 1975; Goffman, 1959). The dialogue and verbal interchange that takes place during an encounter, together with gesture and behaviour, depend not only upon the recognition of what the other is saying but also on the interpretation of the meaning conveyed (Blumer, 1969). The professional language becomes a language which is to be understood with implied meanings, that is, mutually recognised by both participants (Tannen, 1992):

‘Well, verbal [communication] as well as body language that you actually feel comfortable with each other.’

Midwife 12: 4 years

In an exchange, consistency of communication with language and its interpretation of the meaning from one person by another achieves a mutual understanding and reinforcement (Gergen, 1969).

Exchanges may be affected by a practitioner's or student's self-confidence, their confidence in each other and their non verbal-behaviour. The level of trust between the two, their communication and interpersonal skills are determinants of their ability to exchange mutually. These determinants influence professionals and students in their interactions in recognising the meanings conveyed by each other.

The data indicated the importance of students receiving frequent messages to obtain feedback on their contributions. Exchanges are media that develop trust. Where a sense of trust emerges from mutual recognition of exchanges, the relationship can enhance learning.

## **Reciprocity and reinforcement**

Both reciprocity and reinforcement result from exchanges. Reciprocity with exchange in human relations is a preferential behaviour (Gergen, 1969) as there is an acceptance by one person of another. Students referred 'openness', 'accessibility' or 'approachability', meaning that they wanted a positive response from the other person. This can be interpreted as reciprocity. Argyle (1973) describes two sequences in an encounter. These sequences are reinforcement and interaction. The first sequence, reinforcement, leads to imitation that may result in learning. In the second sequence, interaction is an active process that encourages reflexivity and facilitates thinking, with action. These processes of dual actions contribute toward thinking and action which are dialectically related in forming praxis (Carr and Kemmis, 1993).

### Reciprocity

Learning skills through relationships occur through training and role modelling (Argyle, 1992). Gergen (1969) introduces the concept of reciprocity in relationships showing that where a 'gift' is involved, each person in a relationship seeks a reward from the other. The student seeks to acquire the skills of the professional. The professional is rewarded by the student's interest and motivation and in the offer of new ideas:

'I think if you have respect for them, their experience, their years in the job and hopefully they feel the same way to you as a student.'

Student 9: 14 months

This reciprocation can be construed as an exchange of 'gifts'. The reciprocal process may elicit a high, low or equal obligation from the receiver (ibid.). The reciprocal

process will depend upon the realisation of one person's meaning of another (see page 230).

Argyle (1973) classifies this exchange as social acts linked to information, freedom and support. Social acts occur within relationships between professionals and students in the following ways: a professional offers students information on a topic and in response the student gives her own ideas; or an experienced student may report back to a professional on tasks undertaken without supervision, seeking and receiving the approbation that is offered. This kind of reciprocity is important in education, as the student seeks to receive knowledge from the expert.

Underlying reciprocity are shared views of a particular value or belief. Pask (1995) implies that meeting and agreeing values within nursing develops a sense of trust. Within personal contact, there exists some forms of affinity or affiliation (White, 1996), which Argyle and Henderson (1990) indicate as 'affiliative needs' with each person seeking to gain rewards from the other. These 'affiliative needs' can be either strong or tenuous depending upon each person. Each person may have different strengths of 'affiliative needs'. 'Affiliative needs' promote a link between two people and, with mutuality, strengthens feelings of trust. Reciprocity in learning transfers from one situation to another and is a precursor to reinforcement to learn in a new situation.

Reciprocal action can be demonstrated through attitudes of motivation by the student to the clinician or the teacher when appropriately responding, resulting in an element of satisfaction by both. The exchange of 'gifts' will depend upon both parties exchanging and recognising similar meanings and interpreting these within the interaction. A condition of accepting the 'gift' is that the receiver has an attitude of receptivity. There can be a mismatch between exchange of the 'gift' and the interpretation of the meaning between each person. Where there is a variation in

cognitive and affective understanding between professional and student with a low obligation of reciprocity there is a potential for dissonance in learning (Elliott, 1995) or disjunction in learning (Jarvis, 1992).

A lack of reciprocity can result from poor communication leading to misunderstanding between two people. Failure to meet, that is through an encounter, means that there is no reciprocity, such as when a teacher does not visit a clinical area or when a student does not contact her mentor midwife when she is asked to.

### Reinforcement

Three forms of reinforcement can result from an interaction. Firstly, is a confirmation of similar understandings. Secondly, is a redefinition of previous meanings, that results from clarification. Thirdly, reinforcement results from approbation to one person of another leading to confidence between them.

In confirming similar understandings reinforcement occurs when exchanges from one person gives recognition to a meaning that is given by the other:

‘I don’t know whether it is because they [other professionals] think the same way as you or they have the same sort of attitude, obviously there are some people that, - almost like there are some people that you feel will respond to you in the right way. Like I want feedback.’

Student 10: 14 months

This responding is through confirming recognition of similar meanings. This first form of reinforcement is when there is a reciprocal exchange to confirm or express understanding. A person attributes meaning to the other person’s actions, gestures, conversations and responses. Whether the meaning is interpreted consciously or unconsciously, there is a response, with an awareness, without necessarily an



interpretation of the discourse (Jarvis, 1992). This also occurs when an action or a request by one person is interpreted by the other as the language or behaviour are produced but does not require any interaction for its meaning to be understood.

Secondly, reinforcement can occur with symbolic interactionism (Blumer, 1969), that is, through interpretation and meaning of an exchange previous understandings can be redefined. This is where confidence in the relationship between the professional and learner is important. This form of reinforcement is often seen in role modelling where an apprentice imitates the actions of the expert professional and learns through repeated interpretations of reinforcement.

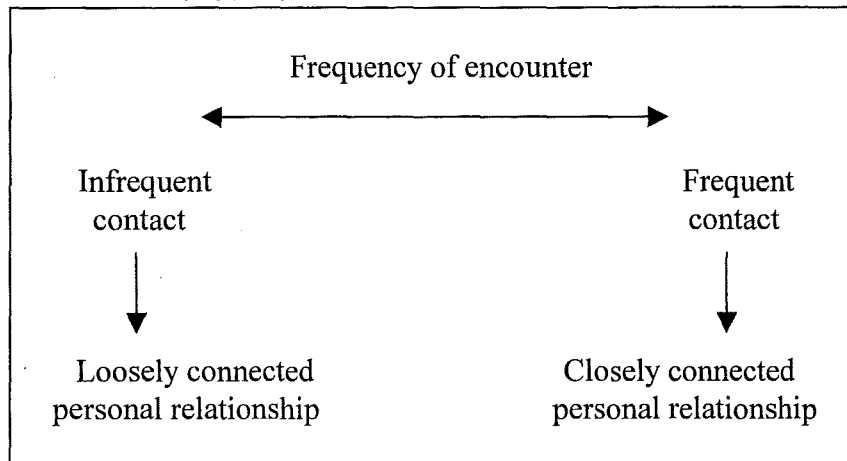
Thirdly, when learning new skills, confidence occurs with reinforcement that is received with approbation. This is needed during the dependent or supervised stage of a student learning. When a student is a novice, reinforcement can be compared to the growth and learning of a child who is reliant on communication verbally and non-verbally for expressions of understanding, and trust (Argyle, 1969), particularly in relationships of dependence (Argyle and Henderson, 1990). Reinforcement can occur with repetitive actions.

There are times when reinforcement does not occur which in turn, affects the effectiveness of learning. The culture and the environment of an encounter can affirm or adversely affect the dynamic of reciprocity.

### **Levels of relationships**

Forming relationships is often referred to conversationally in terms of personal interactions, for example a loose or close relationship. The personal interactions of a relationship may be linked to the frequency of encounter (figure 22):

**Figure 22: Personal interactions in relationships through encounter**



Closely connected personal relationships

All respondents discussed close relationships. In common parlance, a close relationship often refers to an intimate connection, with a meaning of a level of personal sharing of circumstances. As many of the skills undertaken by midwives are intimate and very personal, relationships within a close relationship allow language, touching, and hand gestures, such as caressing with an intimate familiarity that are not normally accepted in other personal relationships, learning these skills entails a close student/practitioner relationship. These non-verbal gestures are acceptable in personal relationships when friendship develops. Words and their meanings also indicate familiarity (Tannen, 1992a). Learning the boundaries, the time and place for these intimate processes requires confidence. This is an important issue in the context of the role model relationship:

‘You respect them because you like the way they are - as a role model to you.’

Student 11: 14 months

However close relationships that are weak with little mutual understanding, for some students, can be inhibiting. It may depend upon how the professional and the student perceive each other. For example, this student appeared satisfied with a mothering approach that other students found constricting:

‘You have a close relationship with somebody almost ‘mothering’ you through it and the changes.’

Student 8: 14 months

Close relationships can create an inappropriate dependence for the stage of training or task to be undertaken. They may inhibit a student to think and act for herself to learn actively. The relationship is dependent upon midwife and student ‘reading’ the individual situation.

Skills such as these are within the domain of acquiring personal knowledge (Polanyi 1958). Polanyi’s view is that students learn through their role as apprentices to a professional. A close relationship is one where the student, as an apprentice, receives support and guidance from the practitioner in the arts of practice. This includes skills development and discussions with clients and learning the boundaries of intimate practices. A student is helped to acquire these skills when apprenticed to a professional who is sympathetic and considerate both to the client and the student’s learning requirements. If there is not a close relationship when complicated clinical situations occur and the student does not interact with understanding in response to the practitioner, the learning experience could be negative and result in learning conflict (Jarvis 1992).

### Loosely connected personal relationships

At the other end of the spectrum, (figure 22.) with infrequent contact, the personal relationship may be loosely connected. Loosely connected relationships may be weak or strong ranging from those that are cohesive or those which are tenuous. A weak relationship is one that is tenuous and where there is little mutual understanding, such as a loose relationship, between teachers and practitioners, when there is little communication to develop an understanding. Students who only meet with their teacher in large groups have a loose relationship. Alternatively a loosely connected relationship may have a strong personal connection that arises from intermittent contact but where there are mutual understandings that brings about a sense of cohesion as suggested by Fraser (2000b) when a student is purposefully enabled to consolidate knowledge and skills through taking a responsibility in caring for women.

Where there is a frequent encounter or contact, there is potential for a close relationship, with interaction and reinforcement. Alternatively there are times when this can lead to a clash of understandings:

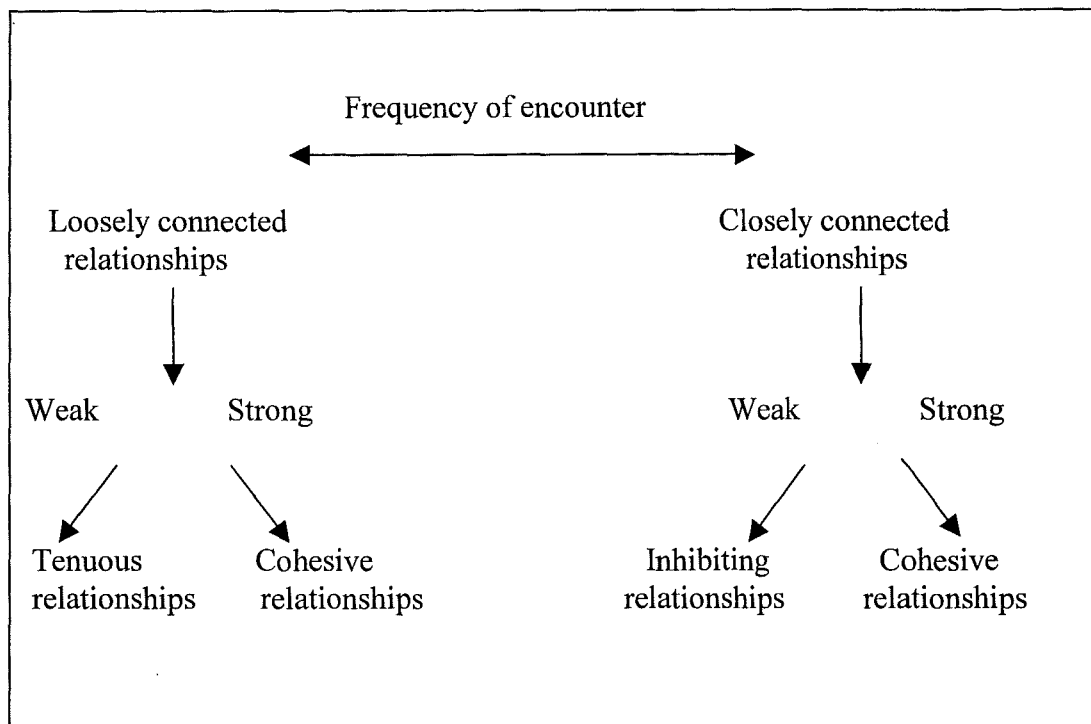
‘Well, she didn’t like the way I practised at all and I found her very, very difficult. She was offhand with me. When we were in the car, I couldn’t make conversation with her; there was never any warmth.’

Midwife 15: 7 years.

Similar affects of adverse relationships in close encounters in student learning are shown in Fraser’s (1996) study of non-midwifery placements.

A diagrammatic representation of the strength of relationships is given in figure 23:

**Figure 23: Strength of relationship through encounter**



The figure demonstrates that there is an association between frequency of an encounter and the possible types of relationships, though the strength of the relationship will also depend upon interpretations of meanings by one person of another. At either end of the spectrum with closely or loosely connected relationships the relationship may be weak or strong. Strong relationships are more likely to result in a cohesive relationship where meanings and understandings are similar. If the closely connected relationship is weak this can lead to a relationship that is inhibiting resulting from misunderstandings of meanings between two people. A loosely connected relationship that is weak may have little ground for mutual understandings. This may result in a relationship that is tenuous.

A strength within a relationship promotes cohesion between two people. There can be a weak or strong relationships at either end of the spectrum. The potential to move

along the spectrum from a distant stance to a closer status of a relationship may depend upon the frequency of personal encounters and the forms of interaction between two people. This is not a static state, but a movement that is dynamic, depending upon the reason for the dialogue. It is one, that as a result of dialogue and gesture, can shift to being closer or looser, depending upon the circumstances.

### Cohesive relationships

A cohesive relationship in student learning can be enhancing with liberation. It may result from a loosely connected relationship where infrequent previous encounters occur but through mutual understandings a cohesive relationship results. Alternatively it may result from a frequent encounter with close relationships.

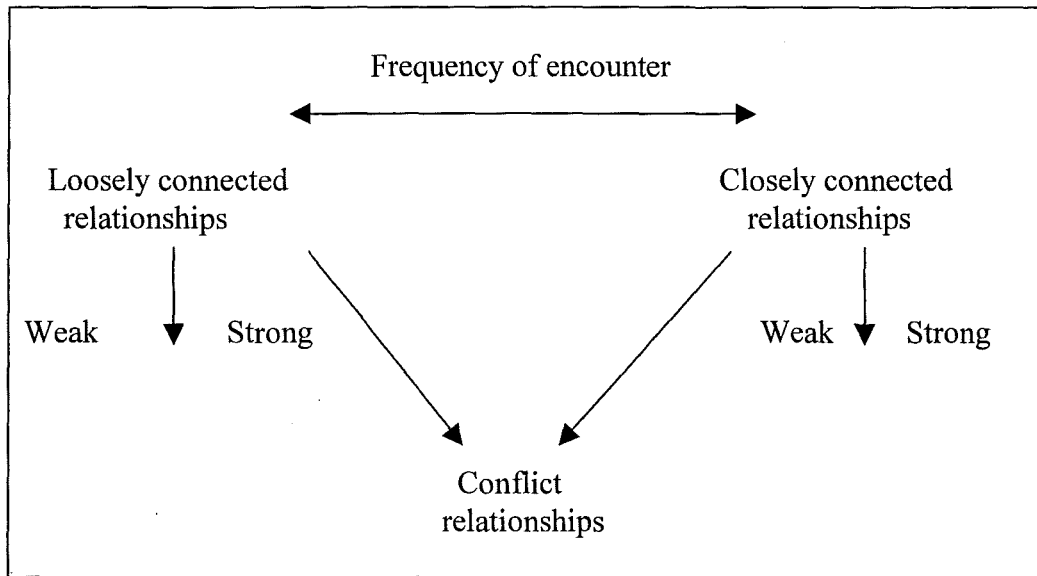
### Inhibiting relationships

However, there may be occasions when close relationships are inhibiting (figure 23.). An example is when a student is not given the freedom to practise to the level of her capability at a particular stage in her educational programme. This will depend upon the people involved and the learning experience.

### Conflict Relationships

Conflict relationships can occur at any stage of the spectrum from close to loose relationships (figure 24.). Conflict relationships occur as a result of an interaction where there is a lack of shared understandings, such as a mismatch of expectations that occurs when curriculum intentions and practice conflict (Fraser, 2000b).

**Figure 24: Conflict relationships**



Conflict may result from failure to observe professional or socialisation rules of adult conventions. Inhibiting relationships will affect a student's ability to learn. Conflicting, inhibiting and power relationships (chapter 9) can overlap. Conflicting or inhibiting learning relationships can result from the following failures in relationship constructions (table 47):

**Table 47: Failures in constructing relationships**

Failures in constructing a learning relationship
<ul style="list-style-type: none"> <li>• Failure in observing the professional and social rules;</li> <li>• Failure to observe boundaries professional/personal and friendship;</li> <li>• Failures in exchanges;</li> <li>• Failure to meet (encounters);</li> <li>• Failure to reciprocate;</li> <li>• Failure to offer reinforcement.</li> </ul>

**Table 48: Examples of failures in construction of each component in building relationships.**

Type of failure in relationships	Failure in construction	Failure in component for building a relationship	Quotation
<b>Conflicting relationships</b>	Failure to observe rules	Lack of agreement in 'vision for practice'/ Failure in 'social and communication abilities'	'I had a student who was aggressive. At the start we had not sorted out the ground rules.' Midwife 12: 4 years
	Lack of reinforcement (Unable to reinforce information)	Failure of 'professional expertise'	'If you go and work with a midwife who is not up to date or doesn't agree with some of the research and is comfortable doing what she already knows and is not willing to change then there is conflict there, you know.' Midwife 6: 5 years
	Failure in reciprocity	Failure of 'personal traits'	'In any relationship if there is no willingness for you to have something in common then automatically there is conflict.' Student 7: 8 months.
	Failure in exchanges	Failure in 'educational knowledge and skills'	'Students find it difficult because... for instance my mothers know me and they are very much looking to me for their care.' Midwife 8: 9 months
<b>Inhibiting relationships</b>			
	Failures in exchanges and reciprocity	Failure in 'social and communication abilities'	'A bad relationship is where there is definitely a breakdown in communication and you cannot relate to each other. Well, it is the hierarchy because some people might think that they can only talk to the same grade. Some people are very easy to talk to and some people are very unapproachable. If you have a problem you will not be able to talk things through.' Midwife 8: 9 years
	Failure in rules	Failure in 'educational knowledge and skills'	'I have worked with one person for a long time but it appears to me that she doesn't have the knowledge of the training and what is expected of me, and that makes it difficult for me, because I don't really know what I am meant to be doing.' Student 9: 14 months.
	Failure in exchange	Failure in 'personal knowledge'	'I think if you have a disinterested student, that is a student that is not interested, then it is difficult.' Midwife 8: 9 years
	Failure in reciprocity	Failure 'personal traits' and 'social and communication abilities'	'If I have gone to a teacher and said 'I've got a problem here' and she has sort of dismissed it. It tends to rebound on you. I think it can affect you indirectly' Midwife 10: 16 years



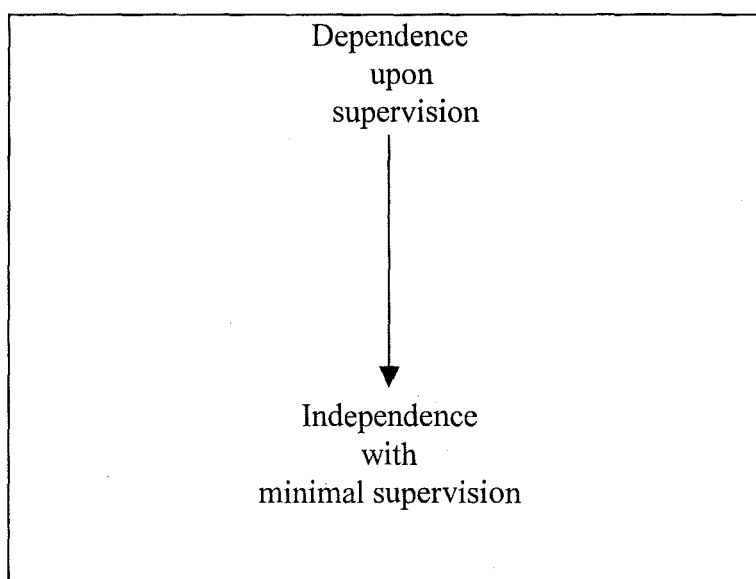
The examples of quotations given in table 48 (page 316) demonstrate how failures in the above constructions of relationships occur in the different components (chapter 8). These are failures in personal traits (core component); social and communication abilities (secondary component); professional expertise; personal knowledge; educational knowledge and skills or a lack of vision for practice (subsidiary components) that inhibit or cause conflict. Conflicting or inhibiting situations have the potential to prevent learning. The strength of a subsequent relationship will be further influenced by the encounters that take place.

### **Levels and learning**

The student, as novice, can be dependent on the professional's supervision during the stages of initial training, but moves to a state of independence with minimal supervision in a particular task or skill, in the latter stages.

This is diagrammatically represented on a continuum figure 25.

**Figure 25: The continuum in a learning relationship**



Moving from a state of dependence to independence, with minimal supervision, can be influenced by the level of interaction between professional and student:

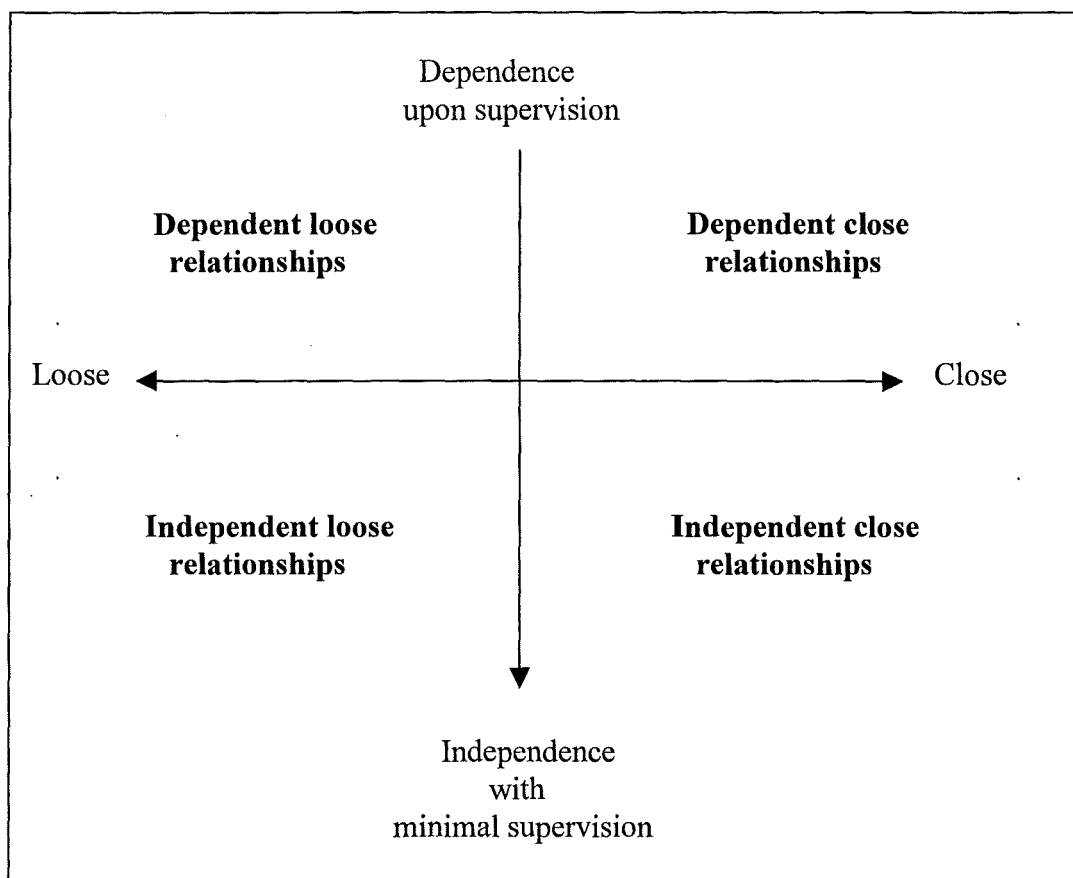
‘Maybe when they are first very new for the first period you are very much more, sort of, responsible for their needs, but when they start to do more, a bit more senior, I mean, they can do quite a lot on their own, but obviously you are still accountable for what they do because you are still supervising them.... you can then let them make decisions and judgements with a bit more freedom.’

Midwife 8: 9 years

The frequency of contact and type of relationship formed affect a midwife’s judgement to assess the student’s ability.

Movement is affected by the midwife’s own self-confidence, her confidence in the student and the level of trust between the two. Movement may also be influenced by the communication and interpersonal skills of both professional and student; their ability to interact and to recognise each other’s meanings using a similar frame of reference. Movement also changes depending upon each task. A student may be independent in one task for example, an abdominal examination for a normal pregnancy but may require supervision to examine a twin pregnancy. This requires dialogue and feedback between each other to stimulate similar understandings. The level of relationships thus forms four quadrants of movement shown in figure 26.

**Figure 26. Learning relationships**



The student's position in the four quadrants: dependent loose, dependent close, independent loose, independent close, will vary according to the situation and frequency of the encounter. These four levels contextualise a student's learning relationships. The position will be dependent upon each individual's 'personal traits' and also the form and frequency of the encounter. The student will move from one quadrant to another depending upon relationship interactions, and the level of trust engendered for the tasks to be undertaken. Learning relationships will move from one quadrant to another dependent upon the stage of training and the level of knowledge and skill required.

When relationships in learning are not able to move along the continuum from a state of dependence with supervision, to one of independence with minimal supervision

that is expected by either student or midwife, the level of relationship between professional and student is not in harmony. There is likely to be disharmony between the expectations of the student and of the professional. Resolving problems of inequable expectations are reliant, firstly, on the relationship itself and how interactions takes place, and, secondly, the discourses that occur between professional and student.

In inculcating the professional culture and character, the student is influenced by those whom she meets and her perceived positive and negative relationships. Each person has an individual template of knowledge, experience and character. Each student forms her own norms and patterns of behaviour, from which she develops her own personal knowledge (chapter 4) and character to form relationships. Patterns emerge from the established norms of professional practice, formed from the socialised norms of the institution and evolved from the professional's own life experiences.

## **Conclusion**

Health care students come into contact with professionals with distinctly different roles. One is the lecturer in the higher education institution, and the other the practitioner dealing with the woman and guiding the student and, though their roles are complementary, they inhabit different realms of discourse in their institutions.

The student adapts to the professional culture in their relationships with teachers, practitioners and other health professionals, through which these socialised patterns are portrayed. Relationships between teachers, practitioners and students are

constructed through three combined notions: rules and boundaries, encounters and exchanges, and reciprocity and reinforcement. Encounters and exchanges are building blocks of a relationship that is further strengthened through reciprocity and reinforcement. Behaviour that demonstrates knowledge of the rules and boundaries cements students into being accepted and socialised within the culture of the profession. Failure to interact within accepted norms in any of these notions creates conflict or inhibits relationships. If the student's self-esteem is diminished, an affective dissonance results, where conditions for learning are inhibited.

Where the anticipated 'gift' in the components, that is of the core component, personal traits and the secondary component, social and communication abilities or the subsidiary component (chapter 8) is not exchanged or reciprocated and there is not reinforcement of the components, there is likely to be either a conflict relationship or one that inhibits a student to learn. This exchange and reciprocation occurs in the relationships between teachers, practitioners and students.

Throughout the education programme, the student moves back and forth within the different levels of relationships in the four quadrants: dependent loose, dependent close, independent loose, independent close, depending upon the type of learning to be acquired. In exploring the constructions of relationships, it is evident that the key elements of self-confidence, confidence in each other and trust in each other are of paramount importance though the components are the building blocks of relationships.. Thus dialogue is essential to ensure that there are mutual understandings between three groups of actors.

The chapter has emphasised not only the importance of teachers, practitioners and students meeting to form relationships but also for each to acquire the appropriate mode of interactions. The above discussion provides the basis for a theoretical foundation of relationships which is central to developing a framework in the next chapter.

## **11 Relationships in practice: a framework**

### **Introduction**

This chapter offers a framework for learning relationships in midwifery education. Three sources that influence relationship formation, their context (chapter 7), the components of relationships (chapter 8), and influences on relationships (chapter 9) are considered. From consideration of these determinants of relationships, a model is offered. Key issues of organisation and structure that impact upon the delivery of relationships are briefly discussed.

### **Forms of knowledge and relationships**

The components of relationships, discussed in Chapter 8, are summarised in table 49. This summary demonstrates the complexity of knowledge forms that facilitate learning relationships, out of which a student formulates her own personal portfolio to understand practice.

Importantly, in relationship building, are the elements within the core (primary) component, that is the personal traits (chapter 8). This component is conveyed and mediated through a secondary component of social and communication abilities. Both these components are *essential* in forming relationships. To state that components are essential means that some elements are exhibited within *all* interactions. Of particular relevance are the concepts of 'ability to trust in others' and 'respect for each other',

**Table 49: Summary of the components and elements which contribute to the formation of relationships in learning professional practice**

Components	Elements
Core component (essential)	<u>Personal Traits</u> <ul style="list-style-type: none"> <li>• Respect for each other</li> <li>• Ability to trust in others</li> <li>• Personal integrity <ul style="list-style-type: none"> <li>- honesty with each other</li> <li>- being reliable</li> <li>- consistency in behaviour</li> <li>- maintaining confidences</li> </ul> </li> <li>• Having self-confidence</li> </ul>
Secondary component (essential)	<u>Social and communication abilities</u> <ul style="list-style-type: none"> <li>• Communication <ul style="list-style-type: none"> <li>- verbal</li> <li>- non verbal</li> <li>- ability to listen</li> </ul> </li> <li>• Social responses to others <ul style="list-style-type: none"> <li>- individually</li> <li>- in teamwork</li> </ul> </li> </ul>
Subsidiary components ( preferential )	<div> <u>Personal knowledge</u> <ul style="list-style-type: none"> <li>• People knowledge</li> <li>• Receptivity to others</li> <li>• Showing friendship and knowing the boundaries</li> </ul> </div> <hr/> <div> <u>Professional expertise</u> <ul style="list-style-type: none"> <li>• Knowledge of midwifery</li> <li>• Research awareness</li> <li>• Knowledge in clinical practice</li> </ul> </div> <hr/> <div> <u>Vision for practice</u> <ul style="list-style-type: none"> <li>• Goals for practice</li> <li>• Standards for practice</li> </ul> </div> <hr/> <div> <u>Educational knowledge and skills of each group</u> <p>Teachers</p> <ul style="list-style-type: none"> <li>• Links theory and practice</li> <li>• Uses clinical skills</li> <li>• Provides feedback</li> <li>• Teaching and education skills</li> </ul> <p>Practitioners</p> <ul style="list-style-type: none"> <li>• Teaching and education skills</li> <li>• Knowledge of the curriculum</li> <li>• Knowledge of assessments</li> <li>• Provides feedback</li> </ul> <p>Students</p> <ul style="list-style-type: none"> <li>• Eager and motivated to learn</li> <li>• Recognises own learning objectives</li> <li>• Understands and accepts the student's role</li> </ul> </div>



that are important in 'interpersonal knowledge' (table 50. discussed in chapter 4). The qualities in interpersonal knowledge (table 50) are displayed though interpretation of the core and secondary components. Therefore, this form of knowledge is associated with personal behaviour and responses. This is an ethical knowledge that brings into play the elements of all three components that is the core, secondary and subsidiary components through peoples' interactions with each other. It is restated here as it is dependent upon the personal traits and social and communication abilities of the individual. This interpersonal knowledge draws upon propositional, personal and process knowledge.

**Table 50: Midwifery interpersonal knowledge**

Knowledge forms	Types of knowledge	Examples of knowledge
Midwifery Ethical Knowledge  'Knowledge- in-use'	<u>Professional Awareness</u> - ethical responses in relationships - trust in others   <u>Professional Responsiveness</u>	<ul style="list-style-type: none"> <li>• Awareness of others 'Attending to the awareness' (Polanyi 1958) of the situation and responding to it</li> <li>• Moral behaviour and ethical responses in relationships</li> <li>• Being empathetic</li> <li>• Using appropriate behaviour intuitively</li> <li>• Recognise women's self-knowledge</li> <li>• Forming relationships with women spontaneously</li> <li>• Promote interactions with others</li> <li>• Respond to and articulate skills to others</li> </ul>

Exchanges (chapter 10) in both first and subsequent encounters are experiences that can be reflected upon and provide a potential for learning (Jarvis 1997). The core component comprises concepts of moral/ethical behaviour derived from social norms of the profession. This core component is conveyed through the medium of the secondary component and is essential to initiate a relationship.

The subsidiary components that are 'professional expertise', 'personal knowledge', 'educational knowledge and skills' and 'vision for practice', are *preferential* in forming relationships in learning midwifery. 'Preferential' indicates that one or more component may be exhibited, for example a teacher may be using educative skills (educational knowledge and skills) at the same time as discussing with the student the values of giving women one-to-one care (vision for practice). However, there are occasions when only one of these components may be exhibited. The subsidiary components are exhibited through the secondary component, that is communication and social abilities.

Professional expertise of midwifery lies in effectively employing propositional, personal and process knowledge (Eraut 1994) and applying these appropriately with midwifery interpersonal knowledge. Exchanges of a propositional nature occur through explanation and discussion. Acquisition of propositional knowledge depends upon a person's subjective self; that is, the emotion of the participant in a situation and relationships between this person and another. Process knowledge depends upon exchanges relating to the practical nature of midwifery in which students observe behaviour and absorb the dialogue. This learning may not require a close relationship. When process knowledge impinges upon matters of intimacy, this may require a

closer relationship. Personal knowledge of an intimate nature can expose personal feelings that require people to move to forms of close relationships.

Where teachers and practitioners have shared understandings of a vision for practice, practitioners demonstrate in their practices principles that are conveyed more formally by teachers to students. Here, there is congruence between professionals with a joint understanding of scientific knowledge between teachers and practitioners. Divergence in views can leave the student with dilemmas in developing skills in practice.

Interpersonal knowledge conveyed from one person to another is an ethical knowledge. This is a form of self-awareness, which occurs in responding to people. It is also professional awareness towards situations in clinical practice in which midwives adapt forms of knowledge and respond appropriately to situations. This includes both knowledge-before-use and knowledge-in-use. Interpersonal knowledge is a form of knowledge that is used when skills are enacted and emphasises the vocational nature of midwifery. In the immediacy of a situation, the midwife reads the scenario as it unfolds and adapts her responses to the individual accordingly. This is a form of conscious theorising.

Relationships in midwifery are dependent upon conveying information at the right level and responding to others through appropriate behaviour and actions. In practice, the student learns behaviour from others and through experience. In her awareness of a situation and others, the midwife is able to utilise appropriate forms of knowledge. Different knowledges are combined when in use.

Professionals convey the above forms of knowledge, all of which are acquired by students, through a reciprocal recognition such as in the realisation of the components in table 49. of the other person. Recognition and realisation of the components will differ with individuals' expectations according to each situation:

'knowledge used in training is not the same as knowledge  
on the job'

(Eraut 1990:25)

This statement indicates that knowledge held by both teachers and clinicians is different. Knowledges acquired by students at the different stages in training also differ from the knowledge of experienced professionals. Students will find that learning evolves from their own experiences and the professional who displays the appropriate knowledge.

Students use knowledge and develop a personal theory through their own practical experiences. Learning the moral behaviour of a professional happens mostly in practice. Professional expertise cannot be acquired without an ethical understanding that is integrated with propositional, personal, process and interpersonal knowledge within the context of practice.

## **Relationships and the context of learning**

Two sequences within a relationship were reciprocity and reinforcement (chapter 10). The latter is influenced by receptivity, which may take place through indirect role modelling in a voluntary process. This is a form of imitation, where one person takes on the behaviour of another. Alternatively, directed role modelling can occur through the professional guiding the student in sequences of tasks and skills in an ordered

fashion. In order to learn, there are further sequences of a) knowledge being conveyed from one person to another and b) knowledge acquisition. These processes are aided by active interaction and critical appraisal, which encourages reflexivity. Frequent encounters lead to replication (Rizzo 1988) particularly when there is consistency of behaviour and attitudes. This will consolidate previous experiences and lead to reciprocity and reinforcement.

Practitioners emphasised that when meeting with students on a one-to-one basis, where meetings occur daily and throughout the day, such as in the community, they were not only able to plan a student's learning experience, but also to provide educational opportunities, dependent upon their knowledge of the student. The midwife to whom the student is linked for supervision is pivotal in students' learning. With frequent opportunities for interaction and exchange, there is time for the teachers or practitioners and students to communicate and recognise individual strengths and weaknesses using reciprocity and reinforcement.

Teachers relate disciplinary knowledge to practical examples in the classroom, though this may not help a student in placing theories of midwifery practice. As a lecturer in the classroom, the teacher's relationship to the student is one that is formal, loose, and in a forum where there may be little personal acknowledgement of the individual with a low level of reciprocity and reinforcement. If students acknowledge the relevance of the theory and can apply this to their professional practice, they respect the teacher for the knowledge imparted and will accept the information given to them. Students who lack respect for a person, or information imparted, either through failure to recognise its relevance, or the style and approach of the teacher, may not learn. If reciprocity is absent replication will not occur. Students intimated that this was more likely to occur when there was little contact with a teacher, for example, attending lectures with other students whom did not share their particular learning interest.

Students suggested that acquiring knowledge in the classroom in subjects such as legislation and anatomy require a formal delivery, such as a lecture. Nursing students apparently adopt a passive learning approach for topics such as anatomy and physiology or medical diagnosis, when a formal style of classroom delivery is used but they use active learning for subjects such as ethics, communication and nursing care (Sutcliffe 1993). The latter subjects relating to the self, such as psychology of pregnancy, attitudes or communications styles, are those that impinge upon the student's own intimate feelings. Confronting subjects such as sexual abuse and childbirth require a closer and less formal structure, such as small group teaching or tutorial.

## **Socialisation and relationships**

Students are socialised to the role of the profession when they imbibe the culture and mostly this effect is imprinted by observation and being with other professionals and clients in practice (Schon 1991a). Socialisation of midwives to the health care culture results in students conforming to the norms of behaviour patterns. The health care culture influences relationship formation, which can be either through power strategies or hierarchy in the relationship or through dialogue and discourse.

### **Personal socialisation**

The midwife who interacts well with clients and recognises the student as a partner in her work, not only provides a role model, but is also someone from whom students can actively learn. The midwife can assist student learning by interpreting and discussing theories of practice from her own perspective. This enables a student to adapt to the midwifery culture, unless the student positively disagrees and rejects it. In contrast, where there is no interaction, no discussion, or no interpretation, the

student has to depend upon her individual learning experiences with clients to develop her own theories of practice. Whilst, in some situations, this can be satisfactory and puts an onus on the student to learn, this is not a relationship with an active learning process. Students' learning opportunities are not maximised. It is mainly the midwife, within her role, who sets the relationship with the student and determines the boundaries for personal learning. Through a personal socialisation the student adapts and conforms her behaviour to the culture of midwifery.

The student, for her part, is expected to conform to her role. Midwives anticipate that students will be interested in their learning, motivated to ask questions, show enthusiasm, and participate with some initiative within their role boundary. Professionals have their own understandings of the boundaries of a student's competence (Fraser et al, 1997, 1998).

From the students' point of view, midwives' requirements of students vary considerably. This depends upon the midwife's personal relationships, and their individual levels of confidence. It appears that the midwife is the major determining influence, with a power that can be used in negative or positive ways in learning (Jarvis 1992; Usher, Bryant, and Johnston 1997). Midwives considered that students, in conforming to an expected role, should recognise when to respond and when to be silent. Midwives indicated that students' contributions to discussion should be appropriate, and that they should recognise situations when dialogue is best not to occur. It emerged that professionals should make known their requirements to students, and students should in return make known their perceived levels of competence. Expectations of each other affect the personal exchanges in relationships. When personal expectations and boundaries conflict, there is potential for disharmony.

## Professional Socialisation

Two areas of professional socialisation occur in relation to a) the professional role and b) accountability. Professional socialisation is a recognition of one's role within a team, acquiring a particular level of responsibility. Socialisation processes are the acquisition of the culture, the reality and norms of the particular profession (Olesen and Whittaker 1970). Processes of socialisation include learning the rules and boundaries of the professional culture of relationships with clients, particularly those bounded by institutional policies and guidelines. In learning within a profession, it is important for a student to be accepted and trusted by other professionals (Eraut et al, 1995).

The role of the midwife is learnt through a coach or apprentice relationship (Schon 1991a) (chapter 5). Both midwives and students suggested that learning the professional mores was achieved through exposure to varied situations. In this way, a student experiences different situations that develop and socialise her into a midwifery culture, through language, behaviour and knowledge of practice:

'It is like being an apprentice. You are picking up what the midwife is doing. You need to work very closely with her.'

Student 10: 14 months

Conformity occurs through individualised learning and through an internal regulation of group norms of behaviour (Sherif and Sherif 1978). Learning the reality of practice is discovering and internalising the norms of the professional society in different situations:

'Students have to learn how relationships work. It is different with different kinds of women. Your attitude to the woman is learned [by the student].'

Midwife 3: 12 years



Reciprocity in a relationship (Argyle 1969), through exchanging shared aims and goals (chapter 8) promotes professional learning:

‘I think the lecturer practitioner and the midwife should have the same values. They are aiming at the same thing. By the end of her training, she [the student] should hold the same values [as the midwife].’

Midwife 5: 2 years

The exchange of philosophies of midwifery care or goals is achieved through language and is conveyed through interaction and social behaviour (Bernstein and Henderson 1973) and by interpretation of the meanings of language.

### **Organisational socialisation**

In this study, students identified learning differences between maternity units that used a philosophy of practice influenced by Changing Childbirth (Department of Health 1993) and those with a more traditional approach. In the former, midwives were recognised as persons with authority but in the latter, where a traditional model of practice was dominant, students perceived a greater theory/practice gap. Information and evidence espoused by teachers in the classroom contrasted with those that were present in practice. Although presented as a theory/practice gap, in reality the gap was a divergence of views promoted by a lack of unity between teachers and practitioners in their vision of practice. This resulted from a lack of communication between them. Thus, this is a gap between education and service interpretations of beliefs for practice rather than between theory and practice as such. For example, in the classroom the student learns that one-to-one practice is an ideal form of midwifery care but in practice she does not find this kind of organisation of care. From a student's perception, it is a gap between education and practice when the two views are not in apposition. Students become familiar with the organisational patterns of care within a maternity unit and are socialised to the unit's culture. In adapting to the institutional culture they adapt to the organisational norms by which the midwives practice.

Teachers' theoretical expositions that are not juxtaposed with clinicians' practice causes student resentment. Whilst this can create disjunction, it can also result in rejection of learning.

### **When learning relationships fail**

Inhibiting relationships (chapter 10) result in diminishing opportunities for students to learn. Conflicting relationships (chapter 10) can stem learning or promote a feeling of 'in spite of the situation' learning is stimulated. These types of relationships lead to a lack of trust and respect. These situations will result in failure of reciprocity between each persons' realisation of the other's personal traits, such as 'confidence in others' and 'self-confidence'. Demonstrations of power of one person over another will also reduce reciprocity and exchange of 'gifts' of personal traits and will also affect the ability of social and communication abilities (secondary component).

### **Power**

A major source of failure of relationships is that of the difference of power within the relationship, where the professional is in a particularly powerful position (Illich 1977). Within a relationship, hierarchical (some), authoritarian or covert power, (discussed in chapter 9) lead to tensions between individuals. Power that is perceived negatively can stem a learning relationship.

Hierarchical power, present in hospital organisations with their marked differentiation of roles, is evident through the culture and behaviour of maternity unit staff. Students can be made to recognise their position vis-à-vis the authority held by a person within this hierarchy, particularly when meeting medical staff in the clinical areas. Power is demonstrated by a person using authority, through language and behaviour that can

subordinate others through speech or attitudes, unless the latter perceives themselves to have a voice. The student, as a novice, can be powerless in the profession, until the student is accorded the space to develop her own voice.

Midwives can use their position to cause students to lose trust. Once trust is broken, and difficult to repair (White 1996) the student is unlikely to use the information further from that source. Loss of trust will result in the student seeking other sources of professional development.

Language is a powerful tool and can instil or negate confidence. Personal power is exacted through language, gesture, and behaviour (Tannen 1992a) which, in a learning relationship, can destroy the confidence of a student when negative, or perceived as negative. This type of power can be covert particularly when an experienced person is relating to a novice. Open demonstrations of power in the presence of a client will especially reduce the student's confidence in herself and her own expertise.

The student is vulnerable as a learner because she depends upon others to expand her own sphere of competence. In most circumstances, the learner seeks to gain confidence in new situations. When a student is experiencing situations that she considers sensitive, she may not always understand the role of the professional or the nuances of behaviour with clients, unless explanations are given. However, it only needs a small gesture from a midwife that is perceived negatively to shatter the student's confidence

### **Negative exchanges**

Two areas that negate or reduce the student's learning are attitudes and behaviours resulting in poor or non-interactions between the two. These, Jarvis (1992) describes as a form of non-action in learning:

‘It’s people that don’t communicate. They don’t speak to you and say what they do and why. They don’t give any explanations, but neither do they have an interest in you as a person, or care what you think or don’t think; they perhaps resent you being there, then you resent being there, and you then resent being questioned and having your practice looked at, and then you know that whatever you are doing is being evaluated. You do not move on [in learning].’

Student 9: 14 months

A failure of communication in the relationship not only produces a vicious circle of negative feelings but also results in the student feeling under scrutiny, so reducing her self-esteem and confidence. This becomes a cyclical process of poor interactions that may result in resentment by either party. This form of non-action in response to learning is akin to a state of anomie, where there is disharmony between individuals and their environment (Jarvis 1992). In student learning, it takes the form of disharmony between people.

If a student’s self-esteem is diminished, motivation is reduced and self-learning retarded. This concurs with Abouserie’s (1995) examination of self-esteem as a determinant of a student’s learning progress. Applied to practice, the student is unable to gain from an experience if self-esteem is diminished, particularly in the arena of a woman or her family. The student will suffer an affective dissonance, which results in self-appreciation being diminished.

Where a feeling of mistrust occurs as a result of frustration or embarrassment, the personal feeling will produce a negative learning experience (Freire, 1966). For example, when a relationship already established with a woman is compromised, the self-confidence of the student can be affected:

‘I built up a relationship with a woman and her partner, and it was close - a one-to-one sort of thing, and when the midwife comes in, the woman looks to her. She [the midwife] said things to her which contradicted what I’d been saying, and I couldn’t do anything. It was

difficult -- I couldn't reach out to the woman. I just sat there. What the midwife was saying was totally wrong. You're there but you cannot do anything.'

#### Student 4: 14 months

This student remembered this as a situation where her self-confidence was diminished resulting in the woman's subsequent lack of confidence in her. This event is particularly significant for her. She felt helpless and could not gain from the situation. She therefore, lost confidence in both herself and further relationships with that midwife.

In some situations, midwives themselves may lack confidence. When a midwife's practice is questioned by students who have more recent theoretical knowledge, both a cognitive and an affective dissonance may be created for the student and the midwife. There is a gap between what the midwife can offer and the expectations or learning aspirations of the student; a failure of reciprocity and reinforcement.

Sentiments expressed by students and practitioners were that teachers, to some extent, have an unrealistic view of practice. For example, a teacher promotes an idealised form of midwifery care, such as continuity of carer. The student, however, is unable to observe this form of practice because of the health service culture. This, students considered, demonstrated a failure of teachers and practitioners to agree common principles for practice and practice beliefs. This could lead to a dissonance between a student's expectations and her experience, and between perceived theories-in-use and espoused theories (Argyris and Schon, 1974). Other areas where relationships might fail (previously discussed) are:

- lack of contact or lack of frequent meetings between the professional and student;
- lack of time made available between midwife and student;
- misunderstandings with different reference frames;
- failure of the student to conform to the role of a student or failure to acknowledge the role of the midwife;

- failure of a clinician to allow the student to move from a state of dependence to independence with supervision;
- failure to recognise the client as central to the relationship in a partnership.

When students are not considered part of the working team and there is a lack of interest in them as individuals, they feel rejected resulting in their inability to participate in learning. However, not all experiences of conflict in relationships result in poor learning situations. Students learn from examples that they consider bad, such as when they feel that a midwife demonstrates inappropriate skills or care. Conflict could be overcome for the student if the teacher or practitioner demonstrated professional expertise that was considered by the student to be experienced and sound in judgement.

## **Framework for relationships in midwifery education**

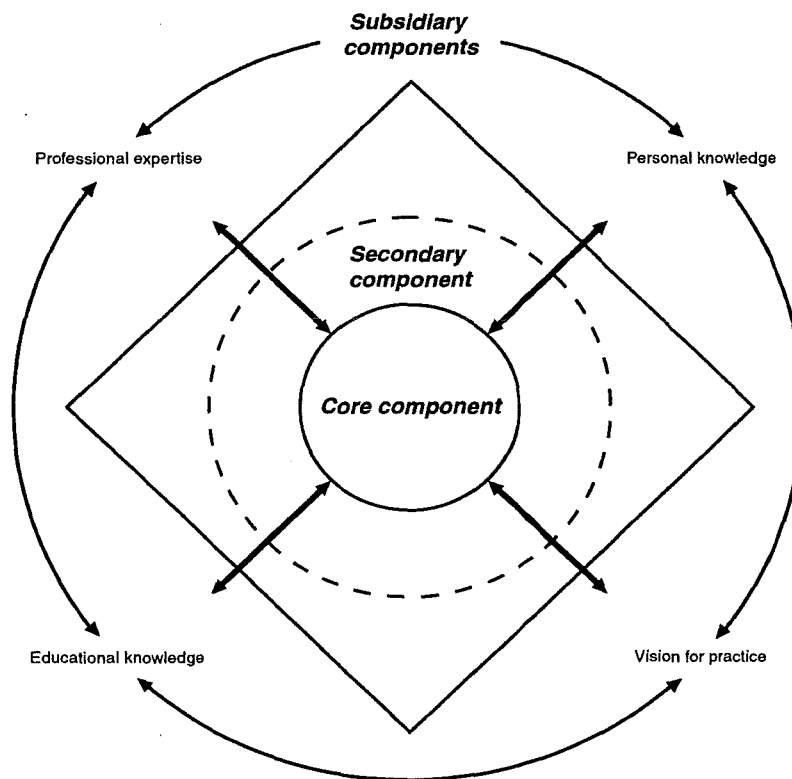
The following framework for building relationships emerged from the analysis of the study. Central to a framework of relationships are encounters. Properties that aid relationship formation are summarised in table 51.

**Table 51: Properties that support educational relationships**

- |  |
|--|
| <ul style="list-style-type: none"> <li>• Personal interaction of the encounter;</li> <li>• The culture of midwifery;</li> <li>• Rules and boundaries;</li> <li>• The elements of the components displayed by the individual ;</li> <li>• The interpretation of the elements in a component by one person of the other;</li> <li>• The nature of the interaction especially the extent of its reciprocity and reinforcement;</li> <li>• The context of practice.</li> </ul> |
|--|

Relationships are formed by each of the actors having their own template of components that are realised by the other person. Figure 27 offers a diagrammatic representation of the template.

**Figure 27. Template of components**



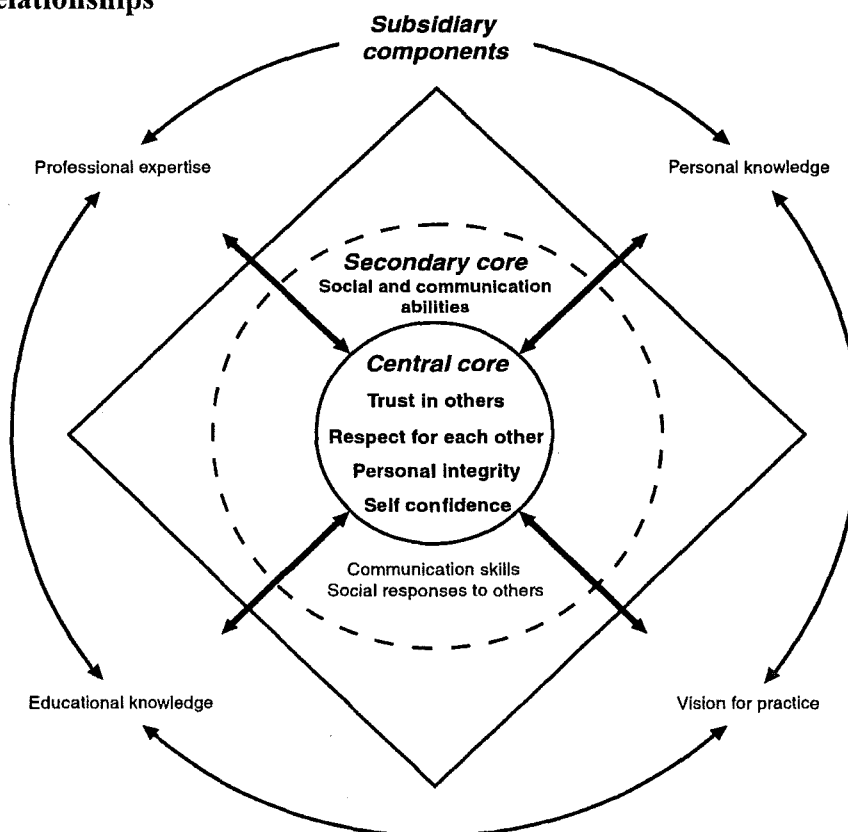
The approximation is to a four dimensional template that has central components, the core and secondary components, with four subsidiary components, one in each dimension. Central in the template is the core component of personal traits and the secondary component of social and communication abilities (table 49.). Each person individually interprets the elements of the other person's core and secondary components. Both people realise the components displayed by the other actor. There is an exchange between actors. This interaction provides the medium through which the elements of subsidiary components can be reciprocated.

The central core is surrounded by the secondary core, through which the personal traits are mediated. It is within normal interactions that interpretations of the core and

secondary components take place. This creates a first form of exchange of 'gifts', prior to exchange of the subsidiary components. This first exchange of 'gifts' of personal traits and social and communication abilities will depend upon each person's symbolic meaning, that is, their individual interpretation of the meaning by the other actor. There will then be a realisation of meaning between the two actors and exchange between them. These are the foundations for realisation of the four subsidiary components of the other person.

A further form of exchange of 'gifts' of the subsidiary component will depend upon the symbolic meaning realised by each person of the other with their expectations of each other. There may not be symmetry in the exchange of the subsidiary components. The template of components form the basis of building a relationship framework as shown in figure 28.

**Figure 28: Four subsidiary components around the central core that facilitate relationships**



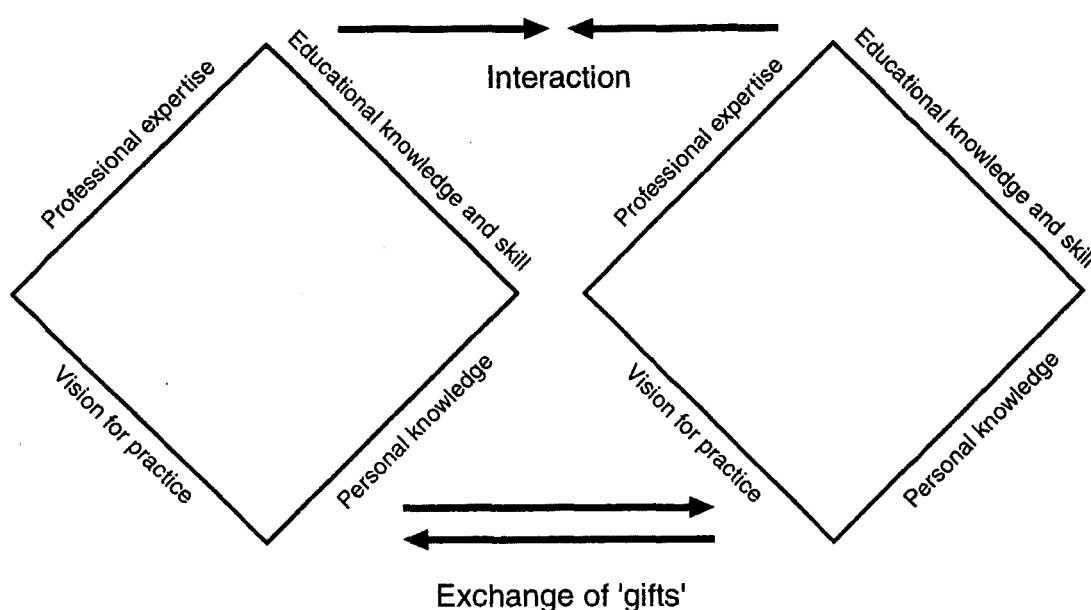
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The above diagram indicates the elements in the central core and those in the secondary core through which elements in the subsidiary components are exchanged.

It can now be posited that *a relationship that promotes learning is one where reciprocal recognition and interaction occur on one or more of the elements of the subsidiary components* (see table 49.). An exchange leads to correspondence of meaning and each individual's realisation of concepts through recognition and interchange (figure 29.).

**Figure 29: Exchange of elements of the components**



Each of the templates in figure 29. relate to an individual actor. Following an initial interaction with an exchange of 'gifts' in the central components there is a realisation of each other's symbolic meaning in the subsidiary components. Further exchanges of 'gifts' of these components occur through interactions.

Exchanges of elements within each of the components will depend upon the perceptions of each actor and their expectation of 'gifts' from the other person. For

example, a student may wish to have information on a specific subject area for a particular task, but the practitioner may not have the ideal pedagogic skills expected by the student. The practitioner conveys messages of knowledge and interaction when with the client, observed by the student. From realisation of the midwife's meanings and interpretation in these encounters the student learns. The student, for her part, may not demonstrate the knowledge that the clinician has expected but shows interest. The messages of knowledge and interaction with the client is realised by the student. The midwife realises the student's demonstration of interest. Thus, in this interaction between the teacher, practitioner and student there is an exchange of 'gifts' though this exchange may not be equal.

It is through their professional discourse and behaviour that the learner and professional reciprocate and develop their relationships. Each encounter may convey a myriad of elements within each component. If the elements of 'ability to trust in others' and 'respect for each other' are not exchanged the student's confidence is reduced. If the student loses her trust and respect it is possible that her motivation decreases.

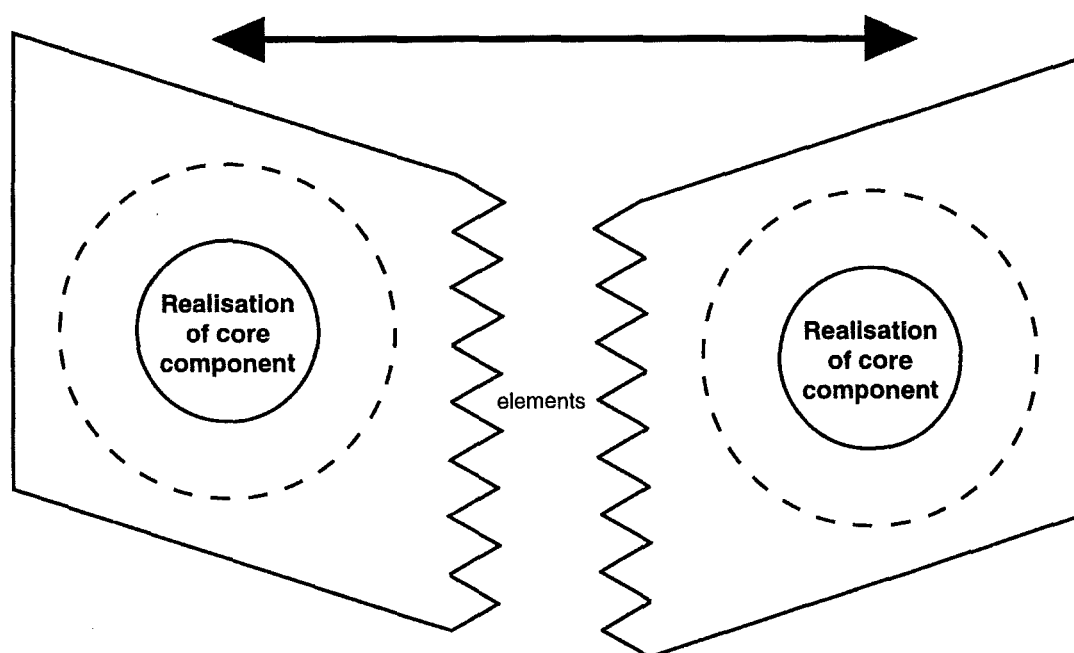
There is a process of giving and receiving. Reciprocity occurs through two processes that are *complementation*, that is, a unity of meaning and therefore a united understanding between the two actors and *complementarity*, a matching of understandings brought about by several interactions that results in an interrelationship between people. These processes may occur separately or in conjunction with each other.

A similarity of elements within the components, displayed by each person, results in a united interpretation of meanings between two people. Thus, each person's

realisation of elements is complementary and forms a united understanding. This unification of two similar states where there is a correspondence of understanding is presented as *complementation*. In complementation, there is symmetry between each person's realisation of the other's meaning of the elements with interactions resulting in exchanges of gifts.

Consistency in behaviour aids complementation, though within a learning relationship there is dynamic movement, as expectations will change with each encounter. Complementation emerges from each actor having expectations of elements within a component that are met by the other person.

**Figure 30: Complementation of elements in relationships**



Complementation will occur when one person offers the other what they want in one of the components in the educational process. There is reciprocity in this interaction, a dual process that can work in either direction. Complementation is diagrammatically

represented in figure 30. indicating some matching of the elements between the same component. There is symmetry in this matching.

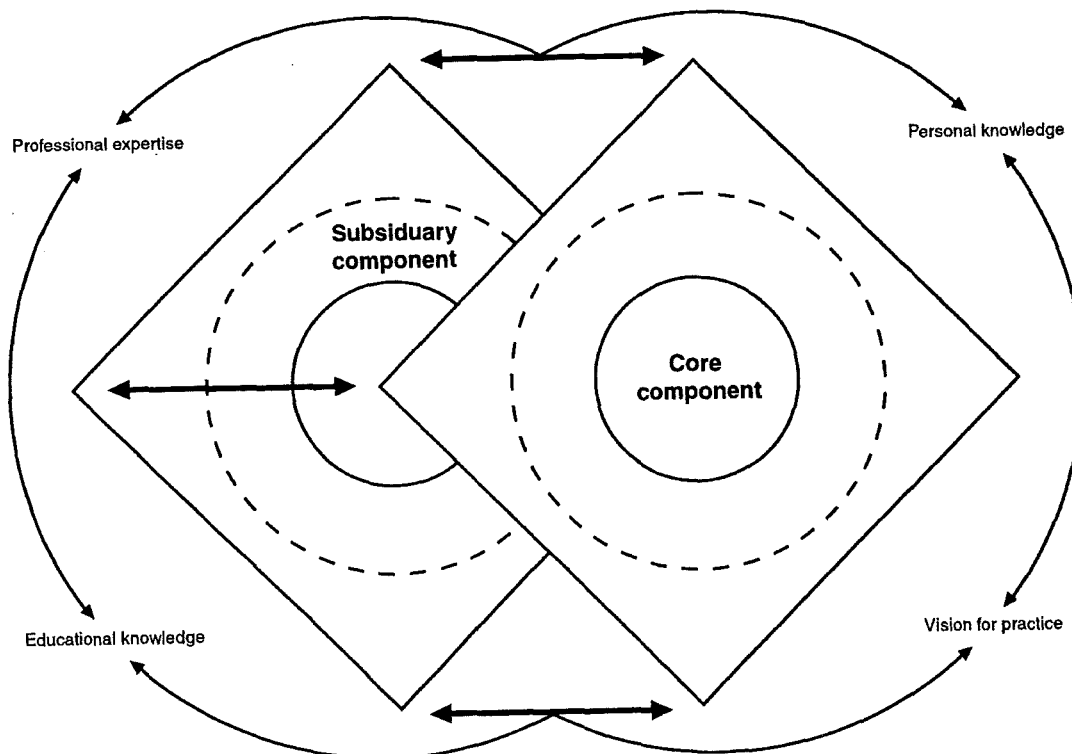
Complementation is aided by each person within the dyad having their own symbolic meanings and interpretative action. Through dialogue, knowledge is discussed and exchanged. The symbolic meaning is shared between the two people. Through an active process between the two individuals with interaction, mutual interpretation can take place. Furthermore, in a mutual exchange with the student, either the teacher or practitioner will recognise a) the student's level of learning and b) the student's state on the continuum of learning from dependence to independence with supervision (chapter 10).

Relationship formation also occurs with complementarity of the elements or components where there is not an initial recognition of each other's meanings. *Complementarity* occurs where there is an interrelationship between one or more of different elements or within different components that brings about a shared meaning. In complementarity there is not similarity of meaning of the elements, but through dialogue or actions there is realisation of meaning by one person of the other. This realisation comes through recognition of 'gifts' from which a shared understanding will result.

Each individual is able to present some of the elements in each component to complement the other person but each individual's expectations of elements may not necessarily be matched by the other person. For example, the professional demonstrates a sound knowledge of neonatal practice (professional expertise). This is evident through her discourse and demonstration in practice, though the student really wants to receive the midwife's personal views of mother's feelings afterbirth

(personal knowledge). However the student demonstrates enthusiasm and interest (educational knowledge and skills component) conveying in her language and behaviour (communication and social abilities component) respect and confidence in the professional (core component). As a result both relate to each other with a shared meaning of interpretation so realising each other's 'gifts'. This form of relationship occurs with repetitive encounters. Expectations of exchanges may or may not be with similarity as in complementation. Though the elements of the components exchanged may not be the same, each person receives a 'gift'. This results in complementarity. Complementarity within a relationship is diagrammatically represented in figure 31.

**Figure 31: Complementarity of elements in relationships**



*A close relationship occurs when there is complementation or complementarity in elements of more than one of the subsidiary components and there is realisation of the core and secondary components:*

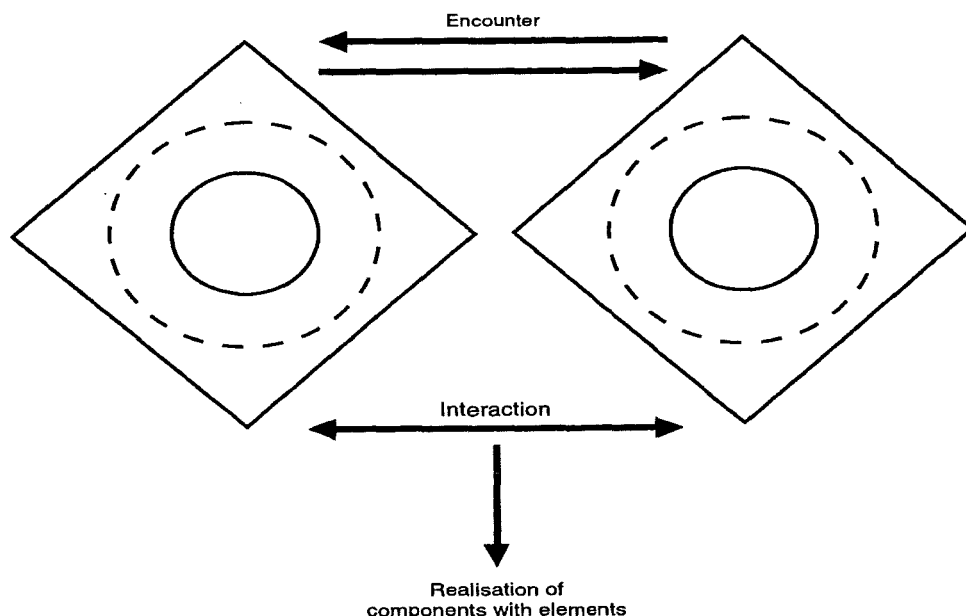
‘You start thinking - Oh, she can’t be that bad, she was quite compassionate to that lady [professional expertise], or she is actually really good at teaching me that certain thing [educational knowledge and skills]. So, in that respect, she might not like me personally [personal knowledge] but there will be a relationship.’

Student 5: 14 months

In this student’s experience with a professional, high reciprocity and reinforcement of elements in components of professional expertise and educational knowledge and skills, and an apparent low reciprocity of elements of personal knowledge are demonstrated. There may also be low reciprocity on personal traits (core component) and social and communication abilities (secondary component).

When encounters between professionals and students lead to a match of elements (complementation) in one component of the template, there is opportunity for exchange and active learning for students. On occasions, practitioners or teachers also learn. Figure 32. diagrammatically represents an encounter between two people when an exchange can take place.

**Figure 32: Movement of relationships through encounter**



Where there is harmony, movement of relationships through encounters lead to students adopting, acquiring and adapting some of the characteristics of the professional. With each encounter, there is reinforcement of the core component. This is a mutual process of reciprocity when both parties may learn from each other but the student is more likely to take on the characteristics of the professional.

An encounter offers an opportunity to adapt to the professional culture through interactions of learning. The process of reciprocity with reflexivity was observed in actions during a situation occurring within a labour ward. A woman suddenly developed a state of severe clinical shock following haemorrhage and had to be transferred to theatre very quickly. Following the incident, the two senior midwives discussed the situation together, analysing this, their own actions and the actions of others. Subsequently, one of these midwives discussed the situation at least six more times with others such as, the student, other midwives, doctors and the senior midwife on duty. At each of these events, the student was present to listen to the narrative as it

was relayed, developed and analysed. She was able to interject, giving her own version, justifying her own account. The midwife, at each iteration, justified, examined and gave a slightly different version with more insight following each person's questions.

In every encounter, concepts of the core and secondary component are exchanged, following interpretation by each person. Also, *some* elements of the subsidiary components are displayed by each actor though the display can be weak or strong. Not all components are exhibited on each occasion with the same strength.

A relationship that promotes learning may not access all the subsidiary components at any one time, though through repetitive encounters and recurrent interactions an association in each component may develop. Relationships are influenced by the student's own self-perception of her ideal role model.

There is a hazard of relationships becoming too close between professionals and students, when a relationship traverses the boundaries of a professional relationship towards personal friendship. Breaking the professional boundaries can lead to an interchange on personal rather than educational issues that can bias assessment and appraisal and role confusion may result.

### **Delivery of relationships**

Curriculum delivery and organisation depends upon the education and the health service institutional structures. Interaction between these organisations and the way in which the curriculum is designed produces the climate in which professional and educational relationships are developed. The curriculum design affects the



opportunities for encounter and exchange. Four key dimensions of curriculum planning emerged:

- provision of a learning climate and the length of a student's allocation to a practice area;
- time spent in interactions between professionals and students;
- links at individual, departmental and institutional levels between education and service areas;
- group sizes of classroom activities.

Provision of a learning climate and the length of a student's allocation to a practice area;

The length of exposure of students to clinical practice areas influences relationship formation, particularly when the student is working in a one-to-one relationship in the community. For example:

'I find it immensely difficult partly because we have them for such a short time.'

Midwife 2: 10 years

Thus, a longer period of allocation to clinical practice areas can aid the student's learning.

The practitioner has an important role in establishing a learning climate for the student.

'The midwife can help to establish a relationship for the student with the client.'

Student 8: months

Other authors (Alexander 1983; Ogier 1989; Spouse 1990) in nursing too have stressed this.

### Time expended between professionals and students

Time is important to give feedback, which students considered an essential constituent in their learning.

‘Time not being given by the tutor is a problem. You then think that she is not interested or cannot be bothered.’

Student 9: 14 months

To develop a relationship, not only contact, but also creating available time for each other impacts on relationship development. Practitioners who give time to students influenced positive views of relationships.

### Links at individual, departmental and institutional levels between education and service areas

For all three groups accessibility to each other was dependent, not only on geographical miles but on modes of transport, parking facilities and the time factor in travelling. Geographical separation of the educational institutions and the clinical areas was considered to be a problem. One result of this separation found by Aston et al (2000) was the reduced attention to the supervision of student. An organisational link between education and service institutions improves perceptions that teachers assist student learning.

‘Some of us feel we want to know more. It would help to have tutors working in the clinical area.’

Midwife 3: 12 years

Opinions of respondents were that a geographical separation effects a negative perception of relationships. Their views were that when the midwifery school was situated within the clinical unit, relationships were better since professionals were

accessible to each other. Practitioners, in particular, sensed a loss of contact with teachers and felt that this was a current shortcoming.

‘Since the midwifery school has moved away there is no communication with the teachers.’

Midwife 12: 4 years

‘Relationships were better when the school was situated within the clinical unit and accessible.’

Midwife 19: 3 years

Teachers, distant through a geographical separation from clinical areas, had weak links with the service. Frequent interchange was not possible. These sentiments conform to those found in studies in nursing (Cavanagh and Snape 1997). The move of colleges of nursing and midwifery into higher education has resulted in the theoretical and practical elements of programmes being separated. Multi-site schools have produced a situation in which teachers have less time in the clinical area and are hardly ever seen by the clinical staff. This also occurs in nursing (Clifford 1993; Clifford 1996). Whilst Aston et al (2000) recommend exploration into the preparation of the practice role of the lecturer, one theme emerging from Day et al’s (1998) work is the importance of interpersonal and intrapersonal skills of the lecturer. Therefore, it is important for forums to be devised so that the three groups of actors meet with each other. The above dilemmas underlie the importance of creating innovative actions in a curriculum in order to reduce the effects of this separation.

#### Group sizes within classroom activities.

Group sizes in the classroom can influence students’ abilities to understand some theoretical information. Using a meta-analysis Smith and Glass (1980) demonstrate the benefits in achievement of class sizes below 30 in school children. In a small

group, adult students are able to explore issues of practice and expand on the theory encountered:

‘When we are in larger groups there are people dominant in personality, the quieter members of the group miss out, only because they cannot contribute. In the smaller groups of us (8-10), we learn directly practical knowledge and skills and the theory. Because we have got to know each other in the smaller group we can share more ... there can be more participation and we are able to tease it out more and be more specific.’

Student 9: 14 months

Small group sizes increase interpersonal and facilitative skills (Feldman, 1984). Increasing the school intake sizes were seen by teachers as a negative influence in building relationships with students. Learning is enhanced by small group sizes (Stockard and Mayberry 1992). It was apparent that where class sizes were above fifteen, students did not always feel able to contribute, which is similar to the findings of Stockard and Mayberry whose studies indicated that, when class sizes were fifteen and below, individual achievement increased. The larger numbers reduce individual interactions that resulted in a lack of an exchange relationship with the teacher.

## **Conclusion**

This study suggests that relationships in education are formed by a realisation, by one person, of the other person's template of components. Through interpretation of their meanings, professionals and students exchange information. ‘Gifts’ within the elements of personal traits, social and communication abilities, professional expertise, personal knowledge, educational knowledge and skills and vision for practice are exchanged during interactions. Realisation of the core component (personal traits) is through the medium of secondary component (social and communication abilities).

These provide the foundation for reciprocity and reinforcement of the subsidiary components that form the basis for learning.

The student learns through the realisation of the other person's subsidiary components. Key to any relationship is the core component of personal traits and the secondary components both of which are essential in a relationship between teachers practitioners and students for a student to learn. These two components create the climate for exchanges of 'gifts' in the subsidiary components. Exchanges of the elements in the subsidiary components are the enablers for learning. Complementation, a unity and realisation of each others' meanings and thus understanding between actors, and complementarity, a matching of understandings brought about by interrelationships between people, are features of learning that occur through behaviour and dialogue. This can create a harmony in learning relationships. These concepts are fundamental to learning within relationships.

Learning occurs through exchanges and interactions between teachers or practitioners and students. Forms of knowledge are reciprocated but this occurs with an exchange of 'gifts' through the processes of complementation and complementarity. These exchanges are influenced by the curriculum and organisational issues. Table 52. gives a framework for relationships in learning.

**Table 52: A framework for learning relationships**

- A template of components for exchanges of 'gifts  
(attitudes/behaviour/values/knowledge/experiences/discourse)
- Processes of complementation and complementarity
- Organisational and curriculum dimensions

Individuals have highly differentiated needs and therefore each interaction is different in its nature. It is the midwife who takes a lead in interactions with both the mother and student thus she has to develop two parallel relationships. Relationships are fundamental to students' learning, particularly within the domains of personal knowledge and midwifery interpersonal knowledge: predominantly when sensitivity or expressions of emotion are required. What emerges is the proposition that midwifery praxis emanates from a) different types of knowledge that combine with human emotions and emotions of women in childbearing and b) from the interactions that take place between professionals and students.

Relationships that students build with teachers and practitioners are pivotal in overcoming dilemmas and difficulties that they encounter, especially in situations that cause personal conflict. When relationships are negative, or in conflict they are likely to disempower the students and negate a learning experience, particularly if an experience involves a client partnership or when a student is encountering new experiences. However, negative relationships can result in passive learning. Where student self-esteem is reduced, an affective dissonance results, that can inhibit learning. When students learn a combination of scientific and humanistic disciplines

that combine with skills of human behaviour, they require multiple knowledges to negotiate their human emotions and personal responses.

## **12 Conclusion: relationships as the basis for professionalism**

### **Introduction**

This thesis has developed a view that relationships, though diverse, may influence the processes of learning, in a profession that is concerned with actions, thoughts, and responses. The context of the study, the contemporary scene of midwifery education, has moved from a state of stability within the health service, to a state of change (Burrows and Loader, 1994). Planning future education so as to be flexible and adaptive to changing work patterns requires mechanisms to be responsive to both environments of health care and education.

Relationships have been shown to affect students' capability to learn. The type and level of relationships created between teachers, practitioners and students must be appropriate for the learning experience and the task to be acquired. Building the appropriate relationships in different learning situations is the task of the educators of midwifery.

Relationships that promote understandings of professional practice are fundamental to learning in a labile environment. Relationships in organisations are particularly important for a profession which is founded on human interactions (Argyris and Schon, 1974). Conflicts in learning can be overcome in an environment that offers students opportunities for exploration and analysis, but that do not daunt or reduce



confidence and expectations. There are five challenges in promoting learning relationships.

*The first challenge* lies upon lecturers and practitioners in acknowledging their own responsibility in creating a climate that fosters learning relationships within organisational structures. Modern institutions are large and systems have moved from collegial organisations within bureaucratic frameworks to managed organisations (Griffen, 1997). The nub for educators is to plan curricula where the process of student learning is valued. Thus, in creating an environment for student learning, power relationships would be positive, rather than negative. This would promote learning through power sharing relationships (chapter 9) to develop partnerships in learning. The ideal of partnerships with women is a goal promoted by government guidelines for maternity care (Department of Health, 1993). This goal for professional practice is difficult to meet in relationships with students, unless the student is recognised as having a responsibility and is recognised as a partner in mutual learning.

*The second challenge* is that of promoting relationships that facilitate knowledge exchange germane to practice (Argyris, 1972). Argyris' explanation of knowledge being germane is that which is applicable, relevant, and serves its purpose:

‘ Knowledge that is germane is so closely related to the subject that its fitness is beyond question.’

Argyris 1972 :82

Germane knowledge is that which is closely akin to the subject or task in practice. It is pertinent and strongly associated to the subject so that it assists the student's understanding. The facilitator has an important role in responding in entering into a

dialogue with the student to enhance her level of knowledge to undertake tasks. The study has shown that the student has a role and responsibility in making her knowledge level and requirements known.

Where relationships in midwifery education develop an active interchange they facilitate a partnership in the learning processes between professionals and students. The teacher or practitioner then can recognise the form of knowledge that the student requires in becoming a competent practitioner. The term active is used to indicate an exchange in which an interaction takes place that promotes praxis. This is an interaction that promotes reciprocity and offers reinforcement to stimulate reflexiveness. Reflexivity results from a deliberate and active analysis of reflection that promotes a further level of conceptual awareness and understanding.

*The third challenge* is that of inculcating flexible approaches in learning within multi-site and complex organisational structures to deliver relationships (chapter 11). The aim is to enable students individually to feel part of their educational process. This will aid relationships to be built with teachers and practitioners. In so doing teachers and practitioners may work together in planning programmes promoting a shared vision for practice. Increased unitisation of educational programmes, and fragmentation of work amongst specialists in the health service, necessitates that even more effort is put into ensuring that education programmes are strongly linked to clinical experience so as to give the student a total picture of professional practice. Also that teachers and practitioners recognise appropriate levels of relationships required for learning different aspects of the course programme.

*The fourth challenge* is that of creating a learning climate, which provides a nexus between theoretical and practical experiences. The crux of this challenge lies in:

a) a curriculum that shows where there is integration of theory with practice. This is where scholarship lies not only in the academic part of the programme, but includes an equal recognition of a scholarship in practice. This encompasses the occupational experience, that goes further than vocational competence in using skills of decision-making and judgement. *Scholarship in practice* is a search for a trustworthiness of decision-making and actions which, in midwifery practice, uses evidence and intuition continually and reflexively to review methods and approaches to care. It involves recognising the knowledges that inform the practice of midwifery (chapter 4) enhancing the wisdom conveyed in practice.

b) pedagogical relationships that offer a dynamic interface between professionals and students. This requires a partnership between teachers and practitioners in fulfilling their separate roles and responsibilities for student learning (chapters 7 and 9).

*The fifth, challenge* is that of creating a climate in which learning relationships are promoted. This will aid interactions that bring about complementation and complementarity so that exchanges take place to promote praxis in learning. The environment creates the atmosphere for overt and covert learning. Covert learning is a form of learning that takes place within relationships and occurs as the student imbibes the actions, attitudes and behaviour of the professionals and is exposed to dialogue in everyday practice. This atmosphere creates an ambience for relationships in learning and the data demonstrated that relationships, particularly in practice with mother and baby affect learning (chapter 7).

Issues arising from this study indicate that there are four levels at which effective learning relationships are promoted. These are:

- I. *The organisational level*, within the structures between the health service and higher education. This is a policy making level, that is currently part of a contracting process. This level creates policies dependent upon economic pressures and is manifested in agreements for numbers in cohorts, funding, agreements for academics, and roles. The policies influence the climate for student learning, both in academia and the health service.
- II. *The levels of negotiation between managers of clinical services and of higher education*. The outcomes of negotiations between managers at this level determine departmental policies, structures and practices which, in turn, influence the environment and atmosphere for learning.
- III. *Within departments*, where the professionals decide and implement the curriculum, determine the contacts and the content and, through their roles, interpret educational processes and practice principles. This affects both the overt and the covert areas of the curriculum. It is at this level that relationships are influential in the processes for learning.
- IV. *The level of individuals* who have a responsibility, themselves, to be committed to learning and to developing their own knowledge and skills in developing professional expertise. This ideal is implicit in the Dearing recommendations for a learning society (Great Britain [Dearing Report], 1997b) and in nursing and

midwifery government strategies (Great Britain, 1997a; Department of Health, 1998b; Department of Health, 1999a).

## **Midwifery education, the health service and higher education**

Two fundamental characteristics are unlikely to change in the foreseeable future. One, midwifery education will remain within higher education with the health service continuing to contract with higher education for professional training. Secondly, the health service will continue to make changes in response to financial constraints and move more of its health care to the primary care setting (Great Britain, 1997a). The emphasis on primary care and public health (Department of Health, 1999a) suggests that students should be more orientated towards the capabilities of self-reliance and resilience characteristics of midwives working in the community, rather than in the structured environments of the hospitals.

Creating a climate in which encounters, discussed in chapter 10, that can take placebo effect relationships and promote learning, requires a knowledge of both the health service and education. The importance of encounters in building the framework for learning relationships as described in chapter 11, indicate that formal arrangements between teachers and practitioners to meet and interact are required in curriculum planning. Those who make funding decisions will need to communicate with lecturers and practitioners to form realistic decisions about educational programme planning, as employers are dependent upon the quality of the educational processes when employing qualified students.

The managers of the two different organisations, higher education and health services, funded separately and with different missions, have therefore a responsibility to develop a mutual dialogue. Their agenda is linked to development of mutual agreements. One, that the health service, actively directs its educational requirements for health professionals. Secondly, that higher education not only recognises the scholarship within a profession's clinical practice and develops this understanding in its curriculum planning but is prepared to invest and explore academic developments of its educators within the practice settings.

Reduced contact time between teacher and student (Barnett, 1997) is changing the pedagogical relationship. A lack of time for students was shown in the data to reduce effective relationships. The time available alters the dynamics of relationships between educators and students. An emphasis on developing educational skills of the student such as self-learning runs in tandem with imaginative ways of teaching greater numbers with less individual time. The educators have a responsibility to engage the students in acquiring reflexive learning skills. Relationships between students and educators become important in encouraging exchanges with reciprocity and reinforcement to develop the knowledges of midwifery.

Recognising practice as an academic activity underlies the development of a partnership for learning. This is not an argument for midwifery to be immune from the organisation of higher education or its structures. It is a plea that education and training for professional practice be designed so as to recognise the intrinsic nature of clinical practice, and the complex knowledge forms contained *within* professional

expertise. It is important that research discovers new ways to innovate in curriculum organisation that give weight to the practice components.

Within the practices of both higher education and the health service is the covert curriculum. It has been shown that this hidden part of the curriculum is displayed through the different types and levels of relationships that the student makes with teachers and practitioners. The covert curriculum is learnt by the student, through her experiences and each student's experiences will differ. Relationships as part of the covert curriculum should ideally be exposed so as to ensure effective relationships are promoted.

A framework for a midwifery curriculum across all institutions could ensure quality with education delivery. The national benchmarking of subjects (QAA, 2001; UKCC, 2001) will go some way to develop national standards and add to the international definition of a midwife and her competence. Quality control is invested within the professional statutory bodies (Department of Health, 1999b).

Prior to the commencement of the study, midwifery education was located within the health service, which was regulated so as to offer free maternity care to the mass population (Gilbert, Burrows, and Pollert, 1992). Changes with economies of scale have altered structures, manpower, and resources for clinical care and education of students. This has resulted in a need to adopt flexible approaches to learning. Use of technology in linking universities to hospital and community practice sites could enhance communication and could, through technical media strategies (Great Britain [Dearing Report], 1997b), bridge a division between health service and education.

Each clinical area will have a link lecturer and a technical video link with the university and other associated clinical settings to enable intersite and university multimedia teaching. Formalised media links would associate the teacher with practice developments and strengthen relationships through media encounters between academics and practitioners and enable flexibility for student learning.

## **Midwifery practice and student learning**

What is the ideal and appropriate preparation for the future professional? Whilst midwifery has predominant features of vocational knowledge and skills, this study has demonstrated the complexity of knowledges that are used for midwifery practice and has exposed its inherent scholarly nature. The four forms of knowledge, (propositional; personal; process and midwifery interpersonal knowledge) are all interwoven. All are essential in the making of a midwife with skills of analysis and reflexivity. Preparing a student in acquiring these multiple knowledges is a joint responsibility of the health service and higher education. Finding the right balance between formal learning in academia and formal training in practice is a problem for both practitioners and teachers. The area that needs attention is formal education by the teacher within the clinical setting. This has been recognised by the UKCC (2000) in developing the role of the practitioner educator. Three forms of educational preparation are necessary. One is the formal education in academia with the teachers. Secondly is the formal education by the teacher in the practice setting to use this area a living laboratory; and thirdly is the training of students alongside expert professionals.



In today's climate in midwifery, a strong consumer representation results in a call for midwifery being centred upon the woman and her choices (Department of Health, 1993). This requires the midwife, as professional, to enter into partnerships with women in their care (Department of Health, 1993) but also demands a professional who is highly skilled (Department of Health, 1998b) and who can adapt to individual situations (Warner et al., 1998). These responsive features, in midwifery, contrast with the idea that a professional has a directing role. In learning interpersonal knowledge (chapter 4) and acquiring skills of critical analysis and reflexivity (chapter 3), the student can develop skills of these negotiation.

An organisational culture that promotes learning is one that fosters actions in learning and learning relationships. It is one where there is a corporate effort and where each individual contributes to the collective goal, and which responds to external changes (Schon, 1983). The culture incorporates an idea that all members of the organisation engage in continuous and collaborative learning (McNair, 1997). The teacher, as part of this collective, could contribute to the quality of learning in the area of practice through raising awareness of practitioners to their potential role in developing scholarship in practice. This requires formal contracts and agreements between leaders of the health service and higher education (Malloch and Laeger, 1997). The teacher is in a two-fold role as an academic and as a clinical teacher. Both roles require agreements for her to be either a teacher in practice or a researcher in either education or clinical practice research. This would promote development of clinical standards for safe practice.

## **Learning knowledge and health care**

The different forms of knowledge in midwifery, that is propositional, personal, process and midwifery interpersonal knowledge are acquired both in higher education and the health service. Theories can be promoted in the classroom, or can be related to the understanding of practice, or can emerge from a professional's practice and from her reflexive understanding of that practice. A student will develop her own learning from theories promoted by others but will also develop her own epistemology of practice from actions-in-practice that integrate with her personal experiences. During practical activities learning combines both theory and practice.

Students in this study found that where theoretical knowledge was not related in the classroom, or was purely discipline based, they were unable to integrate or use this information in their practice. Discussions by students with a practising midwife, whom they held in accord, could help a student in making sense of theories in undertaking clinical practice. In clinical practice, during intimate procedures in close relationships, a practitioner can aid the student in developing her reflexive activity. The study has demonstrated the relevance of professional recognising the appropriate level of relationships required for learning different activities during the progressive stages of training.

Curriculum planning could raise the importance of relationships in practice using a framework that adapts the traditional form of apprenticeship. This would relate the vocational elements to theoretical knowledge so as to bridge the gap between theory

and practice. This gap, however, is not a single entity: it has many dimensions of which three are: differences in values and ideals between education and service; dissimilarities between theoretical knowledge and practice implementation; and variance between theories for research evidence and practice implementation. Students experience the 'gap' in all three areas.

Midwifery propositional knowledge is developing through its own research, and current initiatives are in promoting evidence-based practice (Department of Health, 1998b; Department of Health, 1999a). An epistemology for midwifery is still to be developed. Midwifery could draw more widely from the disciplines of sociology and feminism. There is a contrast between women's knowledge and operational views of knowledge founded on positivistic thought (Barnett, 1993). Developing a curriculum that acknowledges propositional, personal, process and midwifery interpersonal knowledge and obtains a balance between them requires collaboration between educationalists and practitioners. The curriculum will also require recognition of the determinants that build a framework for relationships in learning (chapter 10) to acquire these knowledges.

The curriculum is organised around the ideas held of a knowledgeable practitioner. The curriculum is influenced by the production of knowledge within midwifery and its associated disciplines. Shifting this model more towards a curriculum built around *student experience within clinical practice* could engender an understanding of theory in practice. This requires the traditional apprenticeship model to be adapted in a new academic model.

In the apprenticeship model the student will work alongside a recognised practitioner who will provide mentorship and coach the student. This will aid the building of relationships and the processes of complementation and complementarity. The experienced professional will demonstrate her expertise. The practitioner will assess the student's competence to practise but she will need to continuously develop her own theoretical knowledge to stimulate the student's learning and to promote interactions to sustain reciprocity and reinforcement.

A new academic apprenticeship model working across the health service and higher education could formally recognise the practitioner role in education. This role of the practitioner who mentors a student could be one that is recognised and accredited as an associate instructor within higher education. The practitioner will be fully knowledgeable of the student's requirements to be competent at the completion of the programme. The practitioner would receive formal education for this role. In this model the student will be apprenticed to accredited practitioners who will plan the day today learning experiences for and with the student. The student will take part responsibility for her own learning and for making clear her learning needs.

The teacher would also have a contractual arrangement within the health service though employed by higher education. The teacher will be an advisor to both practitioner and student and have a formal agreement to promote encounters between the triad. The teacher will be a facilitator and will co-ordinate formal teaching links with other lecturers through technical media. She can offer expert knowledge with evidence to practitioners and students. Thus, she will be involved in the development

of the practitioner. In this process the student and practitioner and teacher could be in a partnership to develop the student's competence to practice.

### **The individual in the learning process**

Each of the three actors, the teacher, practitioner and the student have a responsibility in developing their own professional knowledge. Professionals are required to develop their own strategies for their personal development in relation to knowledge and skills within the professions (Great Britain [Dearing Report], 1997b; UKCC, 1999b). Practitioners would be accredited with the university to teach and to take responsibility for students. A planned ladder of development in educational theory and practice could be evolved through continuing education to link with accreditation.

Students recognise that they have two roles, one as a potential academic and the other an embryonic practitioner but may have difficulty in linking the two. The latter, requires an acquisition of advanced qualities of intuition, judgement and decision-making. Students require skills in using active forms of reflection in order to make sense of theory and their practical experience (Schon, 1991a).

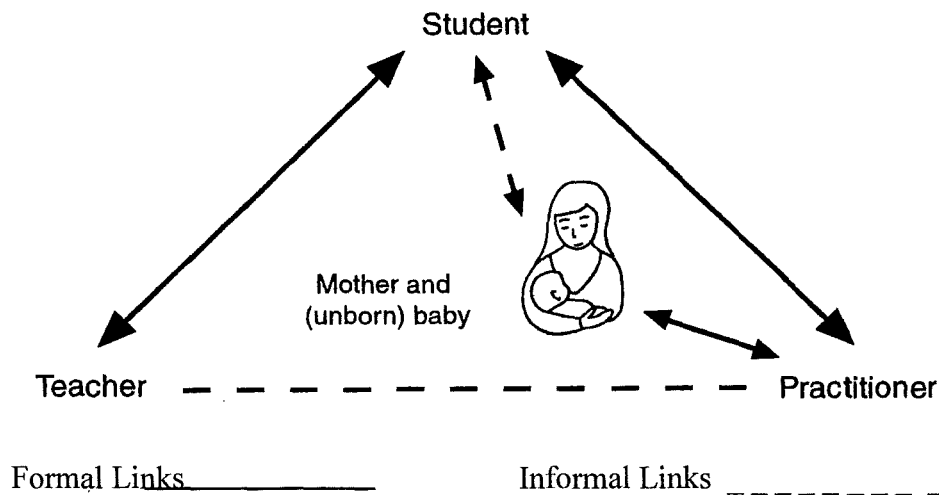
In this study we have seen that relationships that are in harmony aid students' acquisition of knowledge. To enhance students' relationships, teachers and practitioners may need themselves to be self-reflexive in deepening their understandings of their own personal traits and social and communication abilities. Through interactions between teachers and/or practitioners and students with an active exchange of 'gifts', students can be assisted to interpret theory within their

experiences of practice, thus forming their praxis (Freire, 1966). Recognition of rules and boundaries are important in enabling interaction. Self-knowledge by all three groups, teachers, practitioners and students, and recognition of personal traits and social and communication abilities (chapter 8) could enhance exchanges so resulting in all actors holding similar values and a unified vision for practice.

Whilst forming positive relationships with the practitioners are of primary importance for a student midwife because learning in practice involves the inter-subjective self, relationships with teachers are of a different order, but still significant. A view of some students, that the teacher was of secondary importance, suggests a new role should be explored. Whilst the universities are the focus of a student's formal learning culture, students make sense of their theory of professional practice where the experiences of learning take place, that is, where the client is, in a clinical arena.

The differences in professional perspectives on practice have been compounded by the removal of education centres geographically from the clinical sites (Department of Health, 1998a). This may not be so much a theory/practice gap, but a division of responsibilities and ideals in education between education and health service. Teachers, as academics, have competing demands upon their time, such as self-development, research, and publishing (Camiah, 1996). Removal of the teachers from the clinical sites has compounded the emergence of an unequal triad (discussed in chapter two). The model of relationships, apparent in the institutions under study, is represented in figure 33.

**Figure 33: Evident models of relationships**



In this model, the relationships between student and practitioner and between the student and teacher are direct and discrete. There was little teacher/client contact. The lecturer's contact with the practitioner was ad hoc when visiting the clinical sites. Some practitioners did not meet with a lecturer: neither did the lecturers have contact with clients. The diagram represents, therefore, the influence of the mother and baby in relation to contacts between the practitioner and student. It is, therefore, the practitioner/student relationship, with the client as focus that is a major influence in student learning midwifery practice. It is notable that views of students are not in actuality, considered important by some midwives.

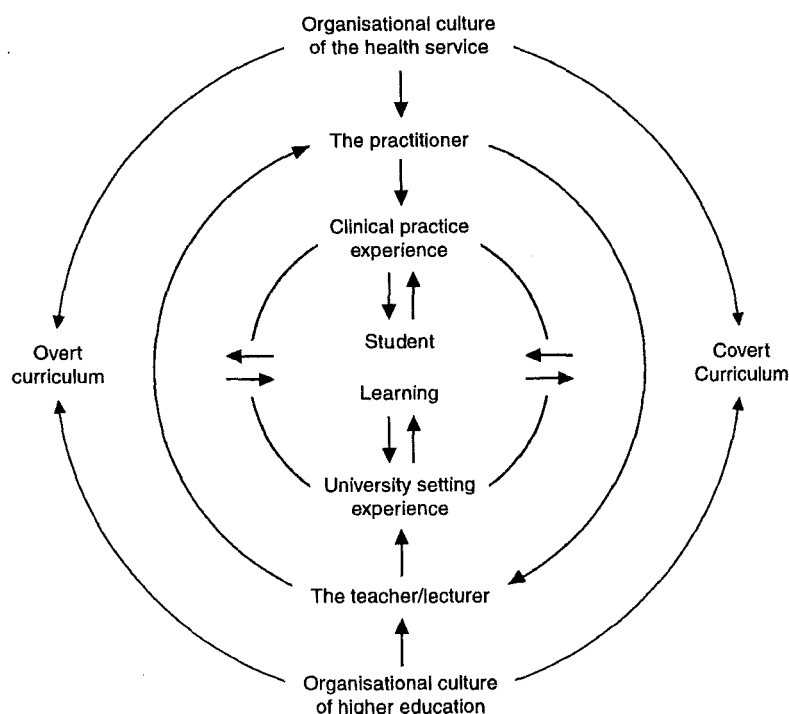
Problems in the relationships were identified:

- Demands were upon the teacher to fulfil multiple roles with the need to travel to clinical sites, sometimes to more than one site;
- There was not a base on all the clinical sites for the teacher to meet or interview students;
- The teacher did not have any formal links or recognition in practice and was without influence on the standards and evolution of practice;

- Practitioner midwives did not identify with the curriculum, and did not have a knowledge of it;
- Students found that theoretical information did not always correspond with the experiences they received in practice;
- Power relationships between teachers and practitioners, practitioners and students and teachers and students had the potential to inhibit learning and the ability of students to develop confidence and independence in practice skills;
- The socialisation processes of students were not necessarily a positive experience.

Relationships in student learning are developed within the context of organisational structures. Figure 34. demonstrates the multi-factors and considerations involved in students' relationships and their learning practices.

**Figure 34: Relationships in midwifery education: structure and context**



The cultures of the two settings weave a tapestry for the overt and covert curriculum. Organisations can be complementary or in opposition. Whilst teachers affect



students' theoretical experience in the university setting, practitioners affect their practice experience, and their relationships with women. Both teachers and practitioners are influenced by the culture and experiences within their organisation. The student is required to make sense of the differences within the context of both organisations. It is through interactions and reciprocal responses, between the professionals and students that an atmosphere is provided within which a student may learn.

### **A model for midwifery education**

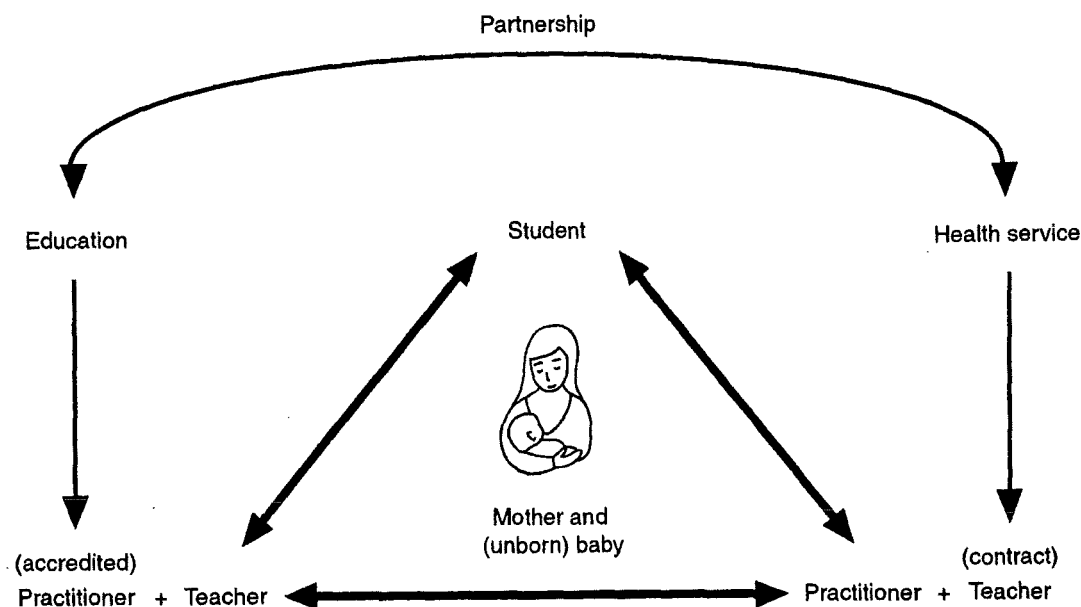
Student learning is dependent upon relationships between teachers, practitioners and students, and the interactions with mother and baby. The analysis indicated that components of personal traits and social and communication abilities provided a medium through which other components could be realised by both parties for interactions to take place. Student's acquisition of the components, of professional expertise, personal knowledge, educational knowledge and skills and vision for practice, depends upon the formation of relationships (chapter 8). A model is proposed to support the development and building of relationships enabling the processes of complementation and complementarity. This model will aid constructions of relationships between each of the three actors by promoting and formalising encounters. Encounters are the basis for bringing into play the determinants of exchanges, rules, boundaries, reciprocity and reinforcement, discussed previously (chapter 10). This will aid complementation and complementarity to form effective learning relationships.

A model for midwifery education is proposed to enable learning to take place between teachers, practitioners and students. The model is also affected by the four levels of

professional organisation that were described on pages 360-361. The way in which the model might be interpreted, however, would be dependent upon the contextual considerations, as shown in figure 34.

The mode of acquiring professional practice is still dependent upon a form of apprenticeship. An adaptation of the traditional apprenticeship model to the cultural climates of higher education and the health service is a way forward. A re-definition of the role of the midwife teacher as academic in having a recognised role in clinical practice would be complemented by the formal recognition of the practitioner as an educator within higher education. This form of partnership between teacher and practitioner in student education and training would place the mother and baby at the centre of learning because both will have a focus of client care and academic requirements. The partnership between teachers and practitioners in educating students will not necessarily be equal. The inequality lies in the function of the different roles. The teacher has the overall planning responsibility for the student's programme and would be accountable for planning the student's programme of learning. However, planning a programme based upon student experience will depend upon the involvement of the practitioner who would develop and be accountable for the student's learning experience in clinical practice. The line of communication between the practitioner and the teacher would be enhanced. A model is proposed to promote relationships between teachers, practitioners and students (figure 35).

**Figure 35: A model for learning relationships in practice**



There are similarities in this model to the model of Barnett, Becher and Cork (1987) in that there is a direct relationship between practitioner and student as apprentice and a direct relationship between teacher and student (chapter one). The difference in this model is the direct relationship between the teacher and practitioner in facilitating the development of the student as an embryonic practitioner. This difference is suggested as a way to build relationships through promoting the determinants of encounters and exchanges, rules and boundaries and reciprocity and reinforcement that will lead to complementation and complementarity. The roles of the teachers and practitioner are repeated on each side of the diagram to emphasise their different roles in relation to each other and the student. The teacher will also facilitate the development of the practitioner and there will be a direct relationship between them. Another issue is the proposal here for the accreditation of the practitioner by the university. These features emphasise a partnership, indicated by the + between both teacher and practitioners and with the student for her learning.

This model includes a direct and three-way relationship between teacher, practitioner, and student to develop the student's practice. This will emphasise the relationship between teacher and practitioner. This is complemented by a two-way relationship between student and practitioner with an apprenticeship model and a two-way relationship between teacher as facilitator of both theoretical and practice learning and the student. Both the practitioner and the teacher have formal links for practice development. There are moves towards the development of the teacher in practice and greater collaboration between service and education with inter-professional learning - all indicators of the importance of learning in practice (UKCC, 1999b; Royal College of Midwives 2002; Department of Health 2000a; Department of Health 2001a).

### **The academic role**

A feature of this model is that a formal role is accorded to the academic in the clinical area in fostering learning between the three actors. Formal arrangements for practice would give the teacher an opportunity to influence the professional development of the maternity unit staff, have an impact upon their practices, and undertake teaching within the clinical practice environment. An essential ingredient will be an agreed contract that recognised the responsibility of the teacher in the clinical area in being accountable for areas of clinical practice, with realistic working agreements. The lecturer would teach in both hospital and university settings. She would link with other lecturers across clinical settings through the medium of information technology.

In this model, the midwife teacher's role to both practitioner and student within the university is recognised to be one where there is a defined contract and a partnership with a health trust. This would be adapted to local circumstances. The teacher not

only has a linked role with a health trust but has a designated role within the management and maternity unit structure, though remaining part of the university academic staff. The teacher could have a management, research or clinical responsibility within the clinical area, with agreed levels of responsibility. This would differ with individuals and with clinical sites. The teacher would be in practice and therefore in contact with the mother and child (McNair, 1997). She will be linked to a specific clinical site. In the role she could undertake a case load; be responsible for an area of research or staff development; or be contracted for development of in-service training programmes. The teacher would maintain and develop her clinical expertise, and act as an expert in one of the three different roles or in an area of specialised clinical practice. Teaching would take place on the clinical site using the university as a resource centre. An example of working, with a lecturer/practitioner having a role as a practitioner, has already been developed (Lathlean, 1992). Challenges admittedly will arise for the lecturer/practitioner in managing such a hybrid role. Its two positions, one in the health service and the other in higher education could bring about a tension arising from being accountable to different employers.

The health trusts and higher education organisations would jointly recognise that a teacher will act in a constant capacity within clinical practice and education to provide a role model, not only to students, but also to clinicians. She would become a specialist in specific areas of clinical practice with a defined role that would be recognised within the work demands coming from the university to whom she is employed. She would guide the clinicians in their role with students.

## **The practitioner's role**

The student would be apprenticed to a designated midwife. The relationship is one where the practitioner has authority. The power relationship is shared between herself and the student and used to guide the student. Her role would be recognised within the academic structure for student learning that would be an accredited position recognised by the university. The practitioner would relate directly to the academic working on that particular site, and there would be a formal agreement between health service and higher education for the work contracted in her role. The practitioner would be responsible for continuing with her own professional development and for the daily planning the student's experiences. Apprenticeship of the student to a practitioner to plan a student's individual curriculum will also facilitate the continuity of student experience.

The practitioner in working alongside the student will plan and create opportunities for the student. She will have a detailed knowledge of the curriculum and the student's progress. In the apprenticeship model, the practitioner will aid the student to reflect upon her experiences (Schon, 1991a), and actively strive to build on the individual's strengths to develop her expertise. The practitioner, through dialogue with the student, will aid the student's reflexive skills and abilities. The student can stimulate the practitioner to understand her own practice. Both will exchange meanings of different kinds of knowledge of midwifery. Through an active interchange within an effective relationship and through recognising the ethical nature of practice, both practitioner and student will develop a praxis of midwifery. Thus, through active learning, the student will formulate her own theory of practice.

## **The student**

As an apprentice, the student would need to develop her skills in self-learning and have responsibility for her own personal development. It is through relationships that the student will gain the confidence to develop her self-learning. Acquiring skills will be activated through a university programme but may be stimulated by experiences in clinical practice by interactions with professionals. This is not a passive role, but one in which the student is enabled to initiate interactions with professionals. In using reflection, students require an ability to challenge and to question, drawing upon their own reflective practice. In learning, students will need to submit to the authority of the practitioners and teachers but there should be a three-way flow of communication, to promote reflective practice (Barnett, Becher and Cork, 1987). Moving throughout the stages of the curriculum, the student aspires to become a master craftsman, through contact with both the academic, with whom she could learn in small groups on the clinical site, and individually to the practitioner, as a role model, who facilitates her skills development.

## **Approaches to underpin learning**

Education contains a sense of improvement (Peters, 1968). Through linking two sites of student learning, collaborative strategies can evolve an educational process that informs and develops practice. To facilitate the above roles, each clinical site would be recognised as a satellite centre for learning by the university with the following resources:

*a) technological links between health trusts and the university*

Learning to be a professional takes place primarily within clinical areas. The problem is to establish cultures of learning in a midwifery setting. Learning would be based on student experiences in practice. This could be made possible through advanced use of media and technology with development of new models through interactive learning. This will benefit all three actors and their relationships. Multimedia conferencing could also be a way of reducing meetings and providing a forum for encounters and dialogue. In particular, teleconferencing between clinical settings could link small numbers of students to a wider experience of education.

Use of interactive learning packages and on-site conferencing could facilitate contact between the student and academic staff, between academic staff and the university and with academics on other clinical sites. Self-learning work packages would be designed for a curriculum that offers a wider scope for broadening theoretical perspectives. Technology can help to achieve learning in practice where students are not moved away from the woman and the clients by providing inter-site links between the academy and clinical setting. Expert supervision at the epicentre of learning, that is at the '*bedside*', will be provided by the practitioner and supported by the teacher. Thus the academic would, in practice, supervise, facilitate and offer staff development. In the clinical setting the clients, women and their families are living laboratories. The interactive relationships with between them will be developed alongside self-learning and with the use of an experienced person, either the practitioner or the teacher. Interactive learning is developing in academic institutions



but to place it within the clinical setting will require new partnerships between health services and academia.

#### *b) Case presentation learning*

Developing a curriculum with a clinical presentation approach, using the experiences of the clinical situation, would offer lived experiences rather than the rhetoric of documents prepared for curriculum. This will relate the theoretical knowledge to practice (Barnett, Becher, and Cork, 1987), and develop a student's knowledge of her practice. Avoiding fragmentation within the curriculum and offering continuity is important in producing a stable learning environment. New mechanisms of technology offer scope for further development to decentralise the university so that the workplace is the hub for learning.

### **Limitations of the study**

The theory evolved in this analysis has been influenced by the author's own background, values and experience. It is possible to recognise and be aware of one's background but one cannot exclude it (Gadamer, 1977).

In developing a grounded theory there is a challenge with a lack of generalisation to a larger population, though the aim of a grounded theory is to be generalisable (Glaser and Strauss, 1967). It is more appropriate to apply the term transferable to the findings as this does not make assumptions that the social context and the reality are

the same in different situations. Thus, this theory is specific to the sample population studied though it could be transferred to a wider population (Strauss and Corbin, 1998). To increase the applicability of this study and transferability, sites for the study were chosen with different educational, demographic and geographical characteristics, though a larger number of sites would have increased the representativeness and, thus, the rigour of the study. Literature was also drawn from different disciplines to note similarities and differences.

The knowledge presented may not be complete as contexts of education change socially, politically and educationally within different periods of time, and the empirical work for this study was undertaken over a period of four years. Neither can it be totally accepted that the four institutions chosen to represent the national picture were fully representative of the diverse characteristics that were within the populations nationally at the time of the data collection, though consideration was given to ensure representativeness of the sample groups chosen.

Miller and Fredericks, (1999) contend that a limitation of a grounded theory is that it produces knowledge of the social world and cannot compare with interpretive research, such as, phenomenology or ethnography but the aim of this study was to explain and illuminate the social world of relationships in midwifery education between educators and students. The role of a grounded theory is to discover new knowledge (Miller and Fredericks, 1999). To assist in the development of an emergent theoretical explanation, the findings of each phase were discussed with colleagues and presented at local, national and international forums for debate and critique. Information received informed the final theory developed. The study was undertaken

at a time of change in the public service organisations and was extended over a long period of time that could result in the findings being outmoded but recent presentations have confirmed that the ideas are current.

The study could have been enriched by explorations of the wider relationships that students hold with other stakeholders, such as, students, other professionals including medical staff, health visitors, and with women and members of their family. Extending the remit of the study to these wider groups would have widened the focus beyond the original intention that is, to understand the triadic relationships between the teacher, practitioner and student. This does not deny that there would be value in developing a wider study to encompass these groups.

The study could have made parallels with relationships between midwives and women more explicit (Kirkham, 2000; Fraser, 1999b; Stapleton et al, 1998) though the place of the mother has been identified in the study. Though brief mention has been made of these relationships further exploration would have extended the study. Development of skills for life long learning through learning relationships could also have been included but a decision was made not to widen the study. The student may use her knowledge gained in developing a personal theory of practice (chapter 4) to adopt life long learning skills.

There are gaps in the areas of the literature that were not explored so as to maintain the focus of the study. These gaps include: explanations of professionalism being limited to a comparison of traditional definitions and not referring to contemporary occupation and professional issues; midwifery as a profession or its emergence as a

profession; definitions of knowledge that review forms of knowing; the literature on roles and role definition; areas of education were not pursued in depth, such as, relationships, and development of competence and relationships and the assessment process. Also the wider literature on the psychology and sociology of interactions was not explored further. The literature used was specific to add definitions and confirm the findings which is the purpose of literature in a grounded theory (Hickey, 1997). Literature was also used as an analytical tool to aid comparison with the data (Strauss and Corbin, 1990).

Research undertaken by the single researcher can result in limited perceptions (Mays and Pope, 1995). To counteract this a self-reflective approach was used to question both data and emergent categories. Reflexivity is promoted by hypotheses generation within the study and a reactive self-questioning process (Strauss and Corbin, 1998). This is a self-conscious approach and notes were kept of the process (Mays and Pope, 1995). Key colleagues were used to review the data and the development of ideas of the emergent themes was discussed with them (Corbin and Strauss, 1990). Theoretical sampling was used in the fourth phase of data collection during which respondents were asked to verify the emerging data (Strauss and Corbin, 1990; 1998). This testing and checking of the emergent theory aimed to increase the credibility of the theory, thus the internal validity of the findings (Tatano Beck, 1993) and was part of the constant comparative analysis (Strauss and Corbin, 1990).

The researcher is an instrument in the process, which has both advantages having the potential to understand the meaning of participants and the language and actions, and disadvantages of not recognising nuances and new phenomena, therefore unable to

make appropriate interpretations (Mays and Pope, 1995). Being able to recognise the respondents meanings in this study had advantages of interpreting the professional language, particularly where problems were presented of an ethical nature in the research interviews. The disadvantages could not entirely be overcome but repeating the different methods for data collection in the three sites and using a self-questioning approach offered new insights into data collected.

There was a line responsibility between the researcher and the teachers, practitioners and the students in one site used that could have altered the responses (Benton and Cormack, 2000). Nevertheless, the mere presence of the researcher will have had some influence on all respondents' responses in the four sites through the nature of the interpersonal interactions and through the role of being a researcher and an experienced professional. This influence was recognised in reflection in the analysis and the approach of constantly comparing each data set in each phase was necessary to ensure validity. However, there was correspondence of the themes that emerged in the data in each phase which aided credibility of the data. The purpose of grounded theory is to gather data until there is saturation of the themes emerging (Strauss and Corbin, 1990, 1998; Strauss 1987). Saturation of themes emerged in phase three of the data, with phase four being used to confirm the majority of themes and complete the gaps or to refute others (Strauss and Corbin, 1990, 1998).

During participant observation the researcher took the role of a student whilst undertaking the research. This could have created a bias or a modification of behaviour of those who were being observed. This is known as the Hawthorne effect (Polit and Hungler 1999). During the event of data collection, the researcher was

placed with experienced professionals who were aware of the research and who were also aware of the lack of clinical skills of the researcher. They did not appear to be affected by the presence of the researcher. There could also have been an effect of an altered response from the students encountered but the emergent themes were confirmed in each subsequent phases, that is, two, three and four.

The questionnaire response rate was disappointingly low, particularly in student groups and a higher response rate would increase the validity of the findings but the overall responses were representative from the different population groups. The purpose of the questionnaire was to obtain data of an exploratory nature and through triangulation of the three sample groups define emerging themes that could be clarified in the interviews. Questionnaire data was confirmed by the interview data. However, the total number of the questionnaires from each group gave a wealth of data that was consistent in responses from each group, thus enabling constant comparison with interview data and the development of the emergent categories and subsequent theory.

Issues of sensitivity arose in the interviews for practitioners, when they were discussing situations where they had poor relationships with students, or with students, when were having current problems in their relationships with teachers or practitioners. On a few occasions it was necessary to discuss personal situations and interrupt the interview. Preferably issues were left until the end of the interview for discussion.

Maintaining a reflective diary has limitations owing to records being biased by personal viewpoints. To guard against this contemporary records were reflected upon with a questioning approach (Strauss and Corbin 1998; Blumer 1969). Whilst software could be used to develop a systematic audit trail (Tesch, 1990; Mays and Pope, 1995), a decision was made to undertake the analysis by hand so that reflection could take place whilst the tapes were being transcribed. The aim was to keep rigorous notes and memos reflecting upon the live interviews so that an audit trail could be followed, thus increasing external validity.

Difficulties arise in a grounded theory by the researcher failing to represent the accuracy of the emerging data with conceptual analysis (Wilson and Hutchinson, 1996). In reproducing the truthfulness of this analysis, the words of the respondents were reproduced as narratives within the text (Slevin and Sines, 1999/2000). Furthermore the final theory developed an analysis from abstraction of the data and linked this to literature through iteration between formal theory and the empirical data.

Rigour in the analysis would have been aided by having an independent assessor involved to monitor the emergent theories (Mays and Pope 1995), though key colleagues were used throughout the period of study and analysis to assist with testing ideas. Accounting for the subjective process in qualitative research is problematic in scientific terms (Hammersley, 1989). The study has attempted to demonstrate the explanation of the processes used but the researcher cannot be separated from it (Hammersley, 1989).

If the study was to be attempted again, different methods might be used to gather the data that could demonstrate more rigour. Alternative approaches could be used such as a personal construct grid or an observation study. Since the data was collected and analysed the government has emphasised the relevance of partnership building within the NHS with collaboration of learning between professional groups (Department of Health, 1998c; 2001a) life long learning and links between education and practice (Department of Health, 2001b). A practical application of the policy changes is to emphasise the nature of learning that takes place in practice through the processes forming a framework for building relationships, which have been identified in this thesis.

## **Summary**

Relationships are complex and this study has had a particular focus on learning relationships in the context of midwifery. Though theories have been drawn from other disciplines, the arguments advanced have been specific to the professional practice of midwifery and the particular sites and institutions studied. A new model, in which the academic is deployed as an expert practitioner, is not entirely new having been followed, in part, by the medical profession. The model will shift the balance of education to the place of the client within practice but utilise the available technology to create a learning culture in multiple settings. Moving midwifery education to higher education brought an awareness of a separation between education and practice. Following the first few years of reorganisation, organisations have crystallised their structures and it is now time to promote a culture and a set of



systems where relationships between the three groups actively promote more dialogue so as to effect productive relationships.

Development of relationships in learning is complex and involves multiples processes that include recognition of rules and boundaries. To build relationships encounters are necessary to provide a forum for exchange and subsequent interactions. Reciprocity and reinforcement pave the way for 'gifts to be exchanged and the processes of complementation and complementarity to take place. These are important in the interchange of components that build relationships to promote learning.

Acquiring the skills, knowledges, qualities and disposition of a professional are a complex set of processes and are associated with the appropriate level of relationships for the type of learning to take place. They are also dependent upon an acquisition of propositional, process, personal and interpersonal knowledges described. There is a complexity in learning that includes such features as respect, trust, personal integrity and self-confidence that are developed over time but only provided that the appropriate relationships are present and of an ethical nature. These are intertwined and integral to the learning process. Their recognition is important to develop praxis.

There will continue to be minimal resources in the health service and education, that, in turn, will demand new forms of delivery and opportunities to strengthen encounters between each groups. Unless we address creative forms of curricula delivery, the divide between education and the health service, with its corollary of a division between theory and practice, problems will increase. Rather than shift theoretical instruction to the university it is necessary to create a balance of realignment of

theoretical instruction within practice so that the roles and relationships between the three actors retain the central importance of the mother and baby, thus giving opportunities for theories to emerge from practice.

This study can only be seen as a part of a larger exploration. Relationships in education are often discussed from the standpoint of one particular discipline. Frequently this is social psychology, but this does not encapsulate the complex dimensions of structure or organisations or epistemologies or professional roles which frame relationships. This study has emphasised the importance of relationships between those responsible for professional education. A student may spend most of her learning time in an organisation which is not part of higher education. The environmental culture and covert learning of socialisation to the profession is relevant here and requires further exploration. Professional relationships are complex and depend upon management structures and organisational policies. Relationships are bounded by human interactions. In this constantly changing society, the importance of recognising the qualities that promote relationships for a student to learn in creative ways is paramount in a society in a state of change.

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## Appendix 1

**Table of key turning points in history of midwifery education**

<u>Year</u>	<u>Agent of action</u>	<u>Change Initiated</u>
1902	Midwives Act <sup>1</sup>	Introduction and initial statutory control of midwifery
1916	Midwives Act <sup>2</sup>	Revised lengths of training. Introduction of shortened training for registered nurses
1926	Midwives Act <sup>3</sup>	Lengthened training
1929	Ministry of Health Report <sup>4</sup>	Recommended recruits to training have academic test  Suggested the training of midwifery teachers
1936	Midwives Act <sup>5</sup>	Major revision of Midwives Act. Introduction of refresher courses for midwives every five years
1946	National Health Service Act <sup>6</sup>	Major health reforms, enabling all pregnant women to have access to free medical care  Midwife Teacher Training Council Set Up <sup>7</sup>
1951	Midwives Act <sup>8</sup>	
1962	Midwives Act <sup>9</sup>	
1960's		Major increase in birth rate, and insufficient maternity beds for demand. Requests for hospital deliveries not available to women who had one uncomplicated pregnancy and who were not otherwise at risk. Introduction of syntometrine routinely and use of syntocinon for induction of labour

1970	Salmon Report <sup>10</sup>	Introduced revised structure of nursing forming a hierarchy based on armed services model
1970	Peel Report <sup>11</sup>	Recommended obstetric care for all pregnant women, to close all small maternity units and offer 100% hospital confinement
1970's		Widening use of ultrasound, introduction of fetal cardiotocographic monitoring  Development of more sophisticated techniques for use of spinal analgesia e.g. epidurals
1970	Mayston Report <sup>12</sup>	Recommended integration of hospital and community services and changes in nursing and midwifery public health departments
1970	Seebhom Report <sup>13</sup>	Introduction of the organisation of the social services which removed the welfare function of midwives
1976	Briggs Report <sup>14</sup>	Recommendation of major changes in nursing and midwifery education and statutory control
1979	Nurses, Midwives and Health Visitors Act <sup>15</sup>	Major reform of the statutory bodies for all nursing and midwifery into combined function of the United Kingdom Central Council and four National Boards Implemented in 1983
1981	Short Report <sup>16</sup>	Recommended hospital confinement, setting up of regional neonatal centres neonatal intensive care units and better training of midwives
1981	Midwives rules <sup>17</sup>	Increased length of midwifery training to eighteen months
1984	European Economic Community Directives <sup>18</sup>	Midwifery directives specified details for education of midwives
1980's	Criteria for Midwifery Training <sup>19</sup>	Introduction of curriculum frameworks for midwifery education

		<p>pupil midwife changed to student midwife</p> <p>Independent midwives setting up in practice</p> <p>Rise of concern of lay organisations of the technicalisation of birth.</p> <p>Emergence of natural childbirth movement</p> <p>Organisations such as BirthRights emerged</p> <p>Reduction in the number of student nurses in training and therefore the recruitment to midwifery training in the next five years</p>
1983	Department of Health and Social Security funded research project: The Role and Responsibilities of the midwife <sup>20</sup>	This research report identified the erosion of the midwife's skills and the duplication of midwifery care between health professionals
1986	Working Together - Government Report 21	A report of the Departments of Employment and Education setting the scene for the development of National Vocational qualifications, and setting up of The National Council for Vocational Qualifications in England, Wales and Northern Ireland
1989 - 1992		Mergers of schools of nursing and schools of midwifery
1992	Working for Patients Government White Paper <sup>22</sup>	Working paper 10 which set the scene for re-organisation of midwifery education
1990-1996		Schools or colleges of nursing and midwifery merged within higher education
1991	ENB Circular 23	All education programmes for midwives to be at the minimum of diploma level

1992	The Winterton Report <sup>24</sup>	A Government report recommending a maternity service which recognised the woman as the focus of care
1993	Changing Childbirth <sup>25</sup>	Report of the Expert Committee setting out Indicators of success in implementing a woman centred midwifery service
1997	Government White paper for the Health Service <sup>27</sup>	Changes to the organisation of the National Health Service
1997	The Dearing Report <sup>28</sup>	Reforms for higher education
1998	Midwifery: Delivering Our Future <sup>26</sup>	A. Health Department report setting out the future for the maternity services
1999	Making a Difference <sup>29</sup>	A strategy for the future of nursing and midwifery
1999	Fitness for Practice <sup>30</sup>	Review of nursing and midwifery education by the UKCC

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<sup>26</sup>Department of Health, “Midwifery: Delivering Our Future: Report by the Standing Nursing and Midwifery Advisory Committee,” (London: Departments of Health, 1998).

<sup>27</sup>Great Britain, “The New NHS: Modern - Dependable (Government White Paper),” (London: H.M.S.O., 1997).

<sup>28</sup>Great Britain (Dearing Report), “The National Committee of Inquiry into Higher Education: Higher Education in the Learning Society,” (London: H.M.S.O., 1997).

<sup>29</sup>Department of Health, “Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare,” (London: Department of Health, 1999).

<sup>30</sup>UKCC, “Fitness for Practice: The UKCC Commission for Nursing and Midwifery Education,” (London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1999).

## **Appendix 2.**

### **Data analysis of curricula documentation**

This appendix gives the data from an analysis of curriculum documents for midwifery education programmes for the three year and eighteen months programmes, prepared for validation between 1992 and 1997. They reflect the type of curriculae which were used at the institutions used for research, but have been obtained from a wider number of Institutions to provide the background for analysis of educational literature in chapter 6. This analysis uses 12 curriculum documents from 11 institutions. Documents from the institutions within the study were not all available. The criteria for selecting these documents were:

- that they were validated either at the time the study commenced or during the period of data collection;
- that they represented the types of curriculum that were in the institutions under study; that there was a cross spectrum of documents for degree and diploma programmes;
- that the documents came from a spread of institutions which would be representative of institutions nationally taking into consideration the geographical spread;

That two types of curriculum from one institution were at a different level and the curriculum was not based upon a similar framework:

The documents were reviewed before making an analysis which used the principles of content analysis (Krippendorff 1980), and followed thematic categorisation of the issues pertinent to the curriculum, teachers, practitioners, students, student learning, and relationship in the education process.

### **Contents of tables in appendix**

1. Number of midwifery curricula reviewed
2. Curriculum documents indicating whether they were framed upon national and international definitions and rules for midwives
3. Number of midwifery curricula reviewed: comparing those linked to “old”\* universities and those linked to “new”\*\* universities.
4. Relationship of allocated time between theory and practice
5. Type of educational institution with number of linked clinical sites.
6. Number of students in intakes agreed per cohort per annum
7. Number of intakes accepted per cohort per annum
8. Categories of members of staff involved in curriculum planning and course development
9. Curricula documents indicating whether their philosophy was based on education or practice
10. Text or references given to indicate approaches used for a framework of the curriculum
11. Comparison the “old” and “new” universities for the authors quoted in the documentation for philosophies, frameworks and learning theories
12. Suggested learning and teaching strategies in documentation
13. Emphasis on the student’s role in learning
14. The role of the student during her programme of education
15. Terminology used for the role of the clinician providing education support in clinical areas
16. Expressions of the role of the clinical midwife in relation to the education of students
17. Number of institutions indicating the role of the clinician in educational supervision and assessment in clinical practice
18. The role of the teacher apart from the clinical situation
19. Expressions of the role of the teacher in relation to the education of students in the clinical practice

20. Links between the academics (teachers) clinicians (practitioners) and students and the clinical sites
21. Assessment strategies: emphasis given to theory and practice assessments

**Table 1. Number of midwifery curricula reviewed**

Validation dates	Type of programme			
	Diploma 18 months	Diploma 3/4 years	BSc. and BSc (Hons) 18 months	BSc. and BSc (Hons) 3/4 years
1991	1	3	1	
1992		1		1
1993	2		1	
1994	1			1
1996				
1997				
Total	4	4	2	2

**Table 2. Number of midwifery curricula reviewed: comparing those linked to "old"\* universities and those linked to "new"\*\* universities.**

	Diploma 18 months	Diploma 3 years	BSc. and BSc (Hons) 18 months	BSc. and BSc (Hons) 3/4 years	Total programmes
Old University	2	0	1	1	4
New University	2	4	1	1	8
Total	4	4	2	2	12

\* Old Universities are defined as those universities that before the Higher Education Act were classified as Universities.

\*\* New Universities are defined as those Universities who obtained University status after the Higher Education Act and were previously Polytechnics or institutions of Higher and/or Further Education.

**Table 3. Curricula documents indicating whether they were framed upon national and international definitions and rules for midwives**

Name of authority for guidance with documents giving reference to named definitions and rules	Old University	New University
UKCC*	4	5
E.E.C. Directives	4	4
WHO Definition of a midwife 1972/ 1992	4	5

\* UKCC Midwives Rules Rule 33.3.c 1-11

None of the above guidance on national or international definitions are referred to in one document. This document emphasised the concepts of trust and cooperation between teachers, students and clinicians. These concepts featured as the most important concepts in this documentation with a statement that clinicians were worthy of respect. The documents also gave emphasis to the value of clinical practice.

**Table 4. Relationship of allocated time between theory and practice**

Theory/practice ratio of time allocated	Old University		New University	
Programme	18 months	3 years	18 months	3 years
60 : 40				*
50 :50	2	1	1	*
40 :60	2	1		*
not stated	-	1		
other	-	1	1	1

n = 4

n = 4

n = 2

n = 2

\* (English National Board 1991)

**Table 5. Type of educational institution with number of linked clinical sites**

Type of University	Number of clinical sites with which the educational institution is linked										
	2	3	4	5	6	7	8	8	9	11	12
Old University*		2	1			1					
New University*	1	3	1	1		1			1		

\* The term New University is used for those which had Polytechnic status before the change in Higher Education following the 1992 reforms Higher Education Act

**Table.6. Number of students in intakes agreed per cohort per annum**

	Diploma 18 months	Diploma 3 years	B Sc. and BSc (Hons) 18 months	B Sc. and BSc (Hons) 3 years	Total programmes
Old University	1x 12 1 x10	0	1 x10	1 x10	4
New University	1 x12 1 x18	1 x10 3 x12	1 x10	1 x10	8

1 x the number of students

**Table 7. Number of intakes accepted of cohort per annum**

	Diploma 18 months	Diploma 3/4 years	B Sc and BSc (Hons) 18 months	BSc. and BSc (Hons) 3/4 years	Total programmes
Old University	1:1 1:2	0	1:1	1:1	4
New University	1:2: 1:3	1:1 1:2 2:3	1:1	1:1	8

Number of institutions: per number of intakes of cohorts per annum

**Table 8. Categories of members of staff involved in curriculum planning and course development**

Categories of staff members	Old University n = 4	New University n = 8
Teachers managerial	4	3
Teachers non midwives/other university staff members	1	1
Teachers midwives	4	7
Other experts e.g medical staff x1 lay representatives x1	2	
Clinical midwives	2	6
Student midwives	2	2
Not mentioned		1

**Table 9. Curriculum documents indicating whether the philosophy was based on education or practice**

Type of philosophy	Old University n = 4	New University n = 8
Based on an education philosophy	2	-
Based on a philosophy of midwifery practice	-	2
Based on both a philosophy of education and midwifery practice*	2	6

\* In three curriculum documents there was an emphasis on the vocational nature of the programme.

Though this table is a crude indicator, it is an interpretation of the text in presenting a justification or rationale for the curriculum as well as an interpretation of the learning and assessment strategies discussed within the documentation

**Table 10. Text or references given in the text to indicate approaches used for a framework of the curriculum**

Type of curriculum framework	Old University n = 4	New University n = 8
Product oriented <sup>1</sup>	-	-
Process oriented <sup>2</sup>	3	4
Situational/cultural oreinted <sup>3</sup>	1	2
Eclectic - indicating use of more than one of the above approaches	-	2*

\* One had a bias towards the process approach though indicated several different authors in the philosophy.

Examples of named author given:-

1. None given, though documents indicated an objectives model by use of the UKCC competencies /EEC Directives
2. Stenhouse / Bruner ( the spiral curriculum)
3. Lawton / Skilbeck



**Table 11. Comparison the “old” and “new” universities for the authors quoted in the documentation for philosophies, frameworks and learning theories**

Author cited in text	Old University n = 4	New University n = 8
a) Philosophy and educational framework:		
Bevis		1
Tyler	1	
Stenhouse	3	1
Bruner	1	3
Lawton	2	1
Skilbeck	2	2
Beattie’s fourfold	1	
b) Educational strategies:		
Ausubel	1	
Peplau - Trust and Advocacy		1
Argyris		1
Schon	1	1
Boud		1
Benner		1
c) Learning theories:		
Bloom		3
Jarvis and Gibson	1	
Knowles	2	2
Rogers	2	1
Mezirow	1	
Steinaker and Bell		1
Gagne		1
Boud		1
d) Assessment theories:		
Rowntree		2

**Table 12. Suggested learning and teaching strategies in documentation**

Documentation indicated the following emphasis:-	Old University n = 4	New University n = 8
Ideal of being student centred	-	3
Aim to inculcate the development of students in lifelong learning	2	1
The belief of an androgogical approach <sup>1</sup>	2	2
Focus on practice based learning		2

1. This was named as that of an adult education approach and androgogy as espoused by Knowles 1984

**Table 13. Emphasis on the student's role in learning**

Documentation indicated the following emphasis:-	Old University n = 4	New University n = 8
Self Directed	1	4
Learning contracts with competence based assessments	1	1
Flexible approaches to learning	1	1
Self evaluative and reflective	1	2

**Table 14. The role of the student during her programme of education**

(The ascribed roles of the student in her midwifery education programme)

1. Takes the role of an adult learner
2. Becomes a flexible learner
3..Learns to be self directed
4. Takes responsibility for her own learning

**Table 15. Terminology used for the role of the clinician providing education support in clinical areas**

Stated role in documentation*	Old University** n = 4	New University n = 8
Mentor	1	8
Facilitator	1	1
Preceptor		1
Supervisor	1	
Assessor		6

\* More than one role was indicated on some documents

\* \*One document did not indicate supporting role in clinical practice

**Table 16. Expressions of the role of the clinical midwife in relation to the education of students**

1. The clinical practitioner takes on a teaching role with supervision and assessment.
2. The clinical practitioner takes on a facilitative educative role with the role of assessor.
3. The clinical practitioner facilitates education for clinical practice.
4. The clinical practitioner acts as a role model.

**Table 17. Number of institutions indicating the role of the clinician in education supervision and assessment in clinical practice**

Documentation indicates clinicians in the following roles*	Old University n=4	New University n=8
Clinicians as educators	2	3
Clinicians as supervisors to students	-	1
Clinicians as educators and assessors of clinical practice	-	2
Clinicians as assessors of clinical practice	**	5
Clinicians as facilitators for transference of skills from nursing and learning midwifery skills	1	

Clinicians may take more than one role therefore responses are more than the total number

\*\* One institution indicated that the teachers were to be used as role models and assessors of clinical practice

N.B. All Institutions used clinicians for supervision of students and their learning in clinical practice but the curriculum documentation does not necessarily reflect this.

**Table 18. Expressions of the role of the teacher in relation to the education of students in clinical practice**

1. The lecturer is the personal tutor, clinical supervisor and assessor.
2. The lecturer is a facilitator of clinical practice.
3. The lecturer is a role model at the beginning of the programme during the novice period of the student.
4. The lecturer provides liaison with the clinical staff.

**Table 19. The role of the teacher apart from the clinical situation**

The roles of the teacher in midwifery indicated in the documentation	Old University n = 4	New University n = 8
Personal tutor and theoretical assessor	1	1
Personal tutor and link lecturer with clinical site	1	2
Personal tutor	2	3
Link lecturer	-	2

**Table 20. Links between the academics (teachers) clinicians (practitioners) and students and the clinical sites**

Type of link	Old University n = 4	New University n = 8
Lecturer as a link person (not necessarily a personal tutor)	2	3
Lecturer practitioners on each clinical site		2
Link lecturers are the personal tutor and link with one site		3
None given	2	

**notes**

1. All documentation appeared to place a low emphasis on clinical skills acquisition. The emphasis was mainly directed at theoretical learning
2. One curriculum document placed a large emphasis on trust, respect and mutual co-operation

**Table 21. Assessment strategies: Emphasis given to theory and practice assessments**

Type of assessment used to judge pass criteria at summative stages and completion of programme	Old University n = 4	New University n = 8
Theory only	1*	-
Theory and practice but practice not part of final weighting of marks and not used a pass criterion	-	2
Theory and part practice, used in final criteria of success	2	2
Equal theory and practice	1	2
Not indicated	-	1

\* no mention of clinical skills being assessed

**References**

- English National Board. 1991. Guidelines for the Implementation of Post Registration Midwifery Programmes leading to Part 10 of the Professional Register at Higher Education Level. Circular 1991/08/PAA. London: English National Board for Nursing, Midwifery and Health Visiting.
- Krippendorff, Klaus. 1980. *Content analysis: An introduction to its methodology*. The Sage Commtext Series. London: Sage Publications.

### Appendix 3.

## QUESTIONNAIRE TO MIDWIFERY EDUCATION INSTITUTION

Please complete either by ticking the boxes or responding where asked. More than one tick may be entered in the boxes in response to the questions.

Please clarify answers if appropriate

### PART 1 ORGANISATION OF MIDWIFERY EDUCATION AND TEACHERS

1. Please indicate your type of education institution:

Independent College of Midwifery	[	]
Independent College of Nursing and Midwifery	[	]
Within a New University (former polytechnic)	[	]
Within other University	[	]
Other	[	]

Please explain if necessary

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2. Please indicate the structure for midwifery education in your institution:

Department of Midwifery Education	[	]
Department of Pre-Registration Nursing and Midwifery	[	]
Department of Post Registration and Midwifery	[	]
Other please state and explain	[	]

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If more than one box ticked please explain

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Who is responsible for basic midwifery education programmes in your institution?

	Pre- Registration	Post- Registration
Head of Midwifery Education	[     ]	[     ]
Head of Department of Nursing	[     ]	[     ]
Head of Department of Advanced Nursing and Midwifery Education	[     ]	[     ]
Senior Midwife Teacher	[     ]	[     ]
Course Director	[     ]	[     ]
Other (please explain )	[     ]	[     ]

\_\_\_\_\_

Please clarify your response if necessary:-

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. How many midwife teachers are involved with student midwives?

6 - 8	[     ]
9 - 12	[     ]
13- 16	[     ]
17 and over	[     ]

5. What is the status of the teacher to the students?  
e.g. .

Purely academic	[     ]
Teacher	[     ]
Midwifery lecturer /Practitioner	[     ]
Lecturer	[     ]
Clinical Lecturer	[     ]
Other	[     ]



Please clarify your response to the terms used above if necessary

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6. Please indicate the qualification level of the midwife teachers indicated in the numbers above:

	Number with qualification
Midwife Teachers Diploma	[     ]
Diploma in Midwifery/or Diploma in Professional Studies	[     ]
Post Graduate Certificate in the Education of Adults (PGCEA)	[     ]
Bachelor Degree	[     ]
Masters Degree	[     ]
M. Phil or PhD	[     ]

Please clarify your response if necessary

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7. How many teachers work with students in the clinical area ? [     ]

Please explain below if necessary:

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## **PART 2 LINKS WITH HEALTH AUTHORITIES**

8. What is the organisation of midwifery education?  
within the Health Authorities?

8.1 How many separate Health Authorities, Trusts or  
Units does your midwifery education department  
relate to? [ ]

8.2 How many clinical midwifery units are  
associated with the midwifery education  
programmes that you offer? [ ]

8.3. What are the arrangements for funding of the  
students?

Employee of Health Authority or N.H.S. Trust	[ ]
Bursary from Health Services	[ ]
Bursary from educational grant	[ ]
Other	[ ]

Please explain \_\_\_\_\_

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9. What is the proximity of the midwifery clinical  
service units to the midwifery education department where  
teaching in classroom takes place - in miles

	Education site 1	Education site 2	Education site 3
Unit 1	[ ]	[ ]	[ ]
Unit 2	[ ]	[ ]	[ ]
Unit 3	[ ]	[ ]	[ ]
Unit 4	[ ]	[ ]	[ ]
Unit 5	[ ]	[ ]	[ ]
Unit 6	[ ]	[ ]	[ ]

Unit 7	[ ]	[ ]	[ ]
Unit 9	[ ]	[ ]	[ ]
Unit 10	[ ]	[ ]	[ ]
Unit 11	[ ]	[ ]	[ ]

Please indicate the main administrative site for student midwives and site or sites where the majority of teachers are based on the above chart

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10. Please describe the formal arrangements and links between

clinical areas and the education department.

10.1. Policy making for midwifery education.

Who is responsible for the decisions on student numbers?

Head of Midwifery Services	[ ]
Midwifery Service Managers	[ ]
Senior Midwifery Education Manager	[ ]
Business or Directorate management	[ ]
Regional Health Authority	[ ]
Other (please state )	[ ]

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10.2. Who is responsible for terminating a student's contract?

Head of Midwifery Services	[ ]
Midwifery Service Manager	[ ]
Senior Midwifery Education Manager	[ ]
Head of College of Nursing and Midwifery	[ ]
Senior Nurse Education Manager	[ ]
Other (please state )	[ ]

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10.3. Which clinical staff are involved in planning the midwifery curriculum?

Head of Midwifery Services	[ ]
Midwifery Service Manager	[ ]
Midwifery Sister Grade G	[ ]
Midwives Grade F, E	[ ]
Student midwives	[ ]
None	[ ]

10.4 Do regular meetings take place between midwife teachers and midwifery service staff? [ YES ] [ NO ]

10.5. Are Midwife teachers involved in decisions of clinical midwifery care [ YES ] [ NO ]

10.6. Are clinical staff involved in monitoring the midwifery education programmes? [ YES ] [ NO ]

### **PART 3 MIDWIFERY COURSES**

11. What types of midwifery registration courses do you manage?

Eighteen months certificate	YES / NO
Eighteen months Diploma	YES / NO
Post Registration Degree	YES / NO
Three year pre-registration Diploma	YES / NO
Three year pre-registration Degree	YES / NO
Pre-registration Honours Degree	YES / NO

12. To whom is the student accountable?

Midwifery Service Department	[ ]
College of Nursing and Midwifery	[ ]
University	[ ]
Other	[ ]

Please clarify your response if necessary.

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13. During the course what total service commitment does the student give?

40%	[	]
50%	[	]
60%	[	]
70%	[	]

14. What is the total number of funded students? [ ]

15. How many intakes per annum ? [ ]

16. What is the average class size?  
Please state number in box

Currently	[	]
Planned	[	]

#### COMPLETION OF QUESTIONNAIRE

18. Please give any other comments

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**THANK YOU VERY MUCH FOR YOUR HELP IN COMPLETING THIS QUESTIONNAIRE.**

**Profiles of Institutions in the study**

**Profile of Institution. (Institution W)**

The institution was within an urban area. At the time of the study the College of Nursing and Midwifery was in the process of amalgamating with two other Colleges of Nursing and Midwifery. This was prior to integration with an institution of Higher Education.

Midwifery was offered within a Department of Midwifery Education. The Head of Midwifery Education reported to the College Principal. The Head of Midwifery Education was responsible for all midwifery education programmes, and when the study took place the College offered an eighteen-month diploma programme for registered nurses to qualify as midwives. The diploma programme was validated by a College of Further and Higher Education, which was to be incorporated later into a University.

There were twelve teachers within the department who taught the midwifery programmes, for registration, post registration and continuing education. All teachers were qualified as midwife teachers, with four holding a degree, one at master's level. With the exception of two teachers, those who did not have a degree were studying for one. All teachers worked with students in the clinical areas, and were linked with specific clinical sites.

This College was linked to five clinical midwifery sites. One clinical site was responsible for the accommodation of the education site of the College, though other sites had office premises for the lecturers. Clinical sites were not adjacent to the education centre. The distance between the education centre and the clinical sites was differed between three and twenty miles.

Decisions about student numbers were made by the Health Trust, in conjunction with the Regional Health Authority. There were two intakes of twenty students per annum, with class sizes varying between ten and eighteen students. Students were salaried by arrangements between the Health Trusts and the College, the latter being responsible for the monies.

Students were employees of the College, with the Head of Midwifery Education having responsibility for terminating the employment contract. The student was jointly accountable as an employee to the clinical service area and to the education department. The service commitment of the student was 50% for the first part of the programme and 60% for the second half of the programme.

Curriculum planning involved teachers, clinicians at all grades and students. There were regular meetings between teachers and clinical midwifery staff. Teachers were involved in clinical decision-making and clinical staff were involved in monitoring education programmes.

**Profile of Institution. ( Institution X)**

The location of this Institution was an outer metropolitan area. The Institution was a School of Health Studies, which was an amalgamation of three Schools of Nursing and four Schools of Midwifery, within a Polytechnic.

Midwifery was offered within a Department of Midwifery Education. The Head of Midwifery Education reported to the College Principal. The Head of Midwifery Education was responsible for all midwifery education programmes which were agreed by the School Board, and at the time of the study offered an eighteen month diploma education programme to registered nurses to qualify as midwives.

There were twenty-three teachers within the department who taught on the midwifery programme. Nineteen teachers were qualified as midwife teachers with four holding a first degree, and three with a degree at masters level. Those who did not have a degree or teaching qualification were studying for this qualification. All teachers worked with students in the clinical areas, and were linked with particular clinical sites, where they had responsibility for their personal students.

This education institution was linked to seven clinical midwifery sites within four Health Districts. Two clinical sites offered accommodation for the midwifery education centres. The clinical sites were all within a range of ten miles.

Decisions about student numbers were made by the Health Trusts in conjunction with the Head of School. There were two intakes of twenty-eight students per annum, with class sizes varying between twenty-five and thirty. There was a wide range of post registration courses.

Students were employees of the Health Trusts, with the Head of Midwifery Education having responsibility for terminating the employment contract. The student was jointly accountable as an employee to the clinical service area and to the education department. The service commitment of the student was 50%.

Curriculum planning involved teachers, clinicians at all grades and also students. There were regular meetings between teachers and clinical midwifery staff. Teachers undertook a variety of clinical roles, but did not have direct responsibility for clinical practice other than their clinical work with or without students. Clinical staff were involved in monitoring education programmes.

### **Profile of Institution. (Institution Y)**

This college was within an outer suburban area. This was a College of Nursing and Midwifery in the process of amalgamating with two other Colleges of Nursing and Midwifery, prior to integration within Higher Education, in a Polytechnic which was currently validating the diploma and degree programmes.

Midwifery was offered within a Department of Midwifery Education with the Head of Midwifery Education reporting to the College Principal. The Head of Midwifery Education was responsible for all midwifery education programmes, which at the time of the study offered an eighteen-month diploma education programme for registered nurses to qualify as midwives.

There were seven teachers within the department who taught on the midwifery programme. All teachers were qualified as midwife teachers with two holding a degree, one at master's level. Those who did not have degrees were studying for one. All teachers worked with students in the clinical areas

This education institution was linked to two clinical midwifery sites. One clinical site was responsible for the accommodation of the education site of the College. Clinical sites were between one and a half and ten miles away from the education site.

Decisions about student numbers were made by the Health Trust in conjunction with the Regional Health Authority. There were two intakes of students per annum, with class sizes varying between nine and sixteen.

Students were employees of the Health Trusts, with the head of midwifery education having responsibility for terminating the employment contract. The student was jointly accountable as an employee to the clinical service area and to the education department. The service commitment of the student was 50%.

Curriculum planning involved teachers, clinicians at all grades and also students. There were regular meetings between teachers and clinical midwifery staff. Teachers were involved in clinical decision-making and clinical staff were involved in monitoring education programmes.



### **Profile of Institution. (Institution Z)**

The institution was in a rural area of England. This Department of Midwifery Education was within a Faculty of Health Studies of a university, which was formerly an Institute of Higher Education.

Midwifery was offered within a Department of Midwifery Education. The Head of Midwifery Education reported to an Institute Dean. The Head of Midwifery Education was responsible for all midwifery education programmes, within the agreement of the Faculty Board, and at the time of the study, offered three year diploma and degree education programmes for qualification as a midwife.

There were ten teachers within the department who taught on the midwifery programmes. All teachers were qualified as midwife teachers and all held degrees. Those who did not have a master's degree were studying for this. All teachers worked with students in the clinical areas, and had designated clinical areas with time allocated for a clinical commitment. This time was specifically allocated to work with students, who were personal students, though there was also an intake co-ordinator.

This education institution was linked to five clinical midwifery sites. The education site of the Faculty was within the University campus. Clinical sites were between one and forty five miles away from the education site.

Decisions about student numbers were made through a regional contract with the purchasing agency, which acted on behalf of the Health Authorities. There were two intakes of students per annum, one a diploma programme and one a degree programme, with class sizes of fifteen.

Students received bursaries and the Dean had responsibility for terminating the education contract. Students required honorary contracts during their work in clinical practice. The student was accountable when working as an employee, to the clinical service area. The service commitment of the student averaged 50% over the three years.

Curriculum planning involved teachers, clinicians at all grades and also students. There were regular meetings between teachers and clinical midwifery staff. Clinical staff were involved in monitoring education programmes, and teacher undertook clinical practice in the clinical areas.

**Summary of Institutional profiles:  
Examples of data used for analysis**

**Appendix 5**

The following summaries were made from the profiles at the time of the study period at the institutions. Differences between institutions sometimes reflect the changes that took place between 1992 and 1996:

**Table 1. Type of education institution**

The organisation of midwifery education and the type of institution	Number of institutions
Independent College of Nursing and Midwifery	1
Within a Polytechnic	1
Within the University (former polytechnic)	1
College of Nursing and Midwifery with links with a University	1

**Table 2. The holder of responsibility for midwifery education**

Title of post holder who held responsibility for initial registration of midwifery education	Number of institutions
Head of midwifery education	2
Head of department of nursing and midwifery	1
Senior midwife teacher, not head of a department	1

**Table 3. Courses offered for initial registration as a midwife**

- Traditional 78 week training programmes (Certificate courses)
- Diploma 78 week courses
- Degree 78 week courses
- 3 year Diploma programmes
- 3 year Degree programmes
- Other pre registration programmes:
  - = Adaptation programmes
  - = Back to midwifery refresher courses

**Table 4. General information on numbers of each institution**

	Phase One	Phase Two	Phase Three	Phase Four
Number. of cohorts per annum	3	2	2	1
Approximate number of students in each cohort	10	60#	16	20
Number of midwifery lecturers	8	12	7	9
Number of linked clinical sites	5	7	2	5
Geographical distance from furthest site	20	10	10	45

# cohorts above 50 were divided into two

**Table 5. Roles of lecturers**

Type of role indicated More than one role indicated for lecturers	Number of institutions indicated role
Lecturer only (as pure academic)	0
Lecturer with clinical link	2
Lecturer with clinical remit	1
Lecturer /Practitioner	2

**Table. 6. Policy making on student numbers**

Who determined the policy for student midwife numbers	Number of institutions
Regional health authority / Regional contract	1
Health education consortium	1
Head of midwifery education	1
Head of midwifery services	1

**Table 7. Allocation of student clinical and theoretical time**

Ratio of theoretical to clinical time	Number of Institutions
Theory 50 : practice 50	1
Theory 40 : practice 60	1
Ratio variable on parts of programme. For example: Theory/practice 60:40, 50:50; 40:60	2

**Table 8. Employment status of students**

Arrangements for contract of employment and accountability of students	Number of institutions
Employee and contracted to Health Authority (Trust)#	3
Students received bursaries from Health Authority with an honorary contract for periods of clinical experience (these students were registered for a full time programme with the University)	1

# During the period of the study the management within the Health service altered to Health Trusts which contracted students for employment and Health Authorities, which became the purchasers of healthcare for locality areas.

**Table 9. Different styles of teaching and learning used by all institutions**

- Teaching session
- Group discussion
- Seminar presentation by student
- Clinical teaching
- Individual teacher contact time
- Directed self study
- Undirected self study

**Table 10. Responsibility for termination of a student's contract**

Title of person who held responsibility for termination of a student's contract	Number of institutions
Head of midwifery services	2
Head of midwifery education	1
Head of college of nursing and midwifery	1

**Table 11. Midwifery staff involved in development of curriculum**

Type of involvement in curriculum issues	Managers involved		Midwifery sisters involved		Other midwives involved		Students involved	
	Yes	No	Yes	No	Yes	No	Yes	No
Curriculum development	4	0	3	1	3	1	2	2
Monitoring education programmes	4	0	4	0	2	2	4	0
Regular meetings between teachers and clinical staff	4	0	3	1	0	4	2	2

**Table 12. Involvement of midwifery lecturers in decisions about clinical care**

Involvement of teacher in clinical decisions	Number of institutions
Direct involvement	3
Indirect involvement	1

This analysis of the documents for the profiles of the institutions was used as part of the notes and memos for the analysis.

## Map for settings of the parameters of the study

Principal parameters	Associated parameters
<b>The Settings</b>	
Midwifery Clinical Areas	Other Hospital Areas
- Hospital	
- Community	
Midwifery Education Centres	
- Classrooms	
- Libraries	
- Offices	
<b>The Population</b>	
Midwife students	Managers
Midwife practitioners	Medical Staff
Midwife teachers	Associated health workers
Mother and child	Families
<b>The Events</b>	
Personal contact	Allocations
Meetings	Teaching timetables
Mentoring	
Classroom teaching	
<b>The Processes</b>	
Personal tutor system	
Teaching sessions	
Clinical learning situations	
Contact with practitioners	
Contact with teachers	
Casual meetings and contacts	

Map devised from Miles and Huberman 1984:29

## **Appendix 7.**

### **Examples of letters and communications sent to respondents and institutions for undertaking the research Communication 1.**

#### **Example of initial introductory letter to the head of midwifery education:**

Dear

I am undertaking research into the relationships between midwife teachers, midwife practitioners and student midwives, which influence acquisition of knowledge and skills by the student to become competent to practise.

In order to undertake this research it is necessary for me to make a study of differing organisations which offer pre and post-registration midwifery education programmes.

I hope to undertake the study on sites which contrast in organisation and structure to make comparisons on the areas of study. The main part of the study will be through questionnaires, and selective interviews of midwife teachers, midwife practitioners, and students. Information about the institution will also be helpful.

I should be grateful if I could come and meet with you to discuss the study and your possible involvement. It may also be helpful to have the meeting at a time that is also convenient with the Head of the midwifery services of one or more sites, as the study includes clinical staff. It would be helpful to make contact with the heads of all the midwifery services of areas where midwifery registration programmes take place.

Thank you for your help,

Yours sincerely



## Communication 2

**Example of letter to the head of midwifery education sent once agreement was reached to use the site for the study to obtain an institutional profile.**

Dear

I am undertaking research into the relationships between midwife teachers, midwife practitioners and student midwives, which influence acquisition of knowledge and skills by the student to become competent to practice.

In order to undertake this research it is necessary for me to make a study of differing organisations which offer pre and post-registration midwifery education programmes.

Would it be possible for you to complete the enclosed form so that I may have a profile of the structure of midwifery education within your institution? I hope to undertake the study on sites which contrast in organisation and structure to make comparisons on the areas of study. Would it be possible for you to return the form to me within a month from receipt of this letter? Information about the institution will also be helpful.

I enclose a stamped addressed envelope for return of this profile.

Thank you very much for your help,

Yours sincerely,

### **Communication 3.**

#### **Example of agenda for the meeting held with heads of midwifery education and management, and with staff to discuss the study before circulation of questionnaires**

##### **Agenda for meeting with Service / Education Unit**

#### **1. Purpose of Study**

#### **2. Access, and consent**

Information to staff

How to convey information and gain access

#### **3. Method**

##### **3.1. General profile**

Structure and organisation

Links between education and service

##### **3.2 Questionnaires To all practising midwives (incl. community)**

Teachers

Students

Distribution from staff and change lists

Date of circulation agreed and discussion with staff

Venue and collection of completed questionnaires.

##### **3.3. Interviews recorded**

Approximately one hour

Arrangements for interviews

3-4 in one day

#### **4. Timescale Dates and return dates**

#### **5. General queries.**

#### **Communication 4**

##### **Example of letter circulated with the questionnaires**

Dear Colleague,

I am undertaking a study into the relationships between the midwife teacher, the midwife practitioner and the midwife student, to find out how these relationships influence the manner in which students acquire knowledge and skills to practise competently as midwives.

There are many changes taking place within the organisation of midwifery care and education of midwives. I believe it is important to discover what types of relationships and contacts are necessary between teachers, practitioners and students, to ensure that students achieve the best possible approach to learning the knowledge and skills of midwifery.

The study is being undertaken in two parts. Initially I am sending out a questionnaire to teachers, practitioners, and students to find out what contacts are currently made, which provide the basis for relationships to be formed. Also I am enquiring about views on the relationships between the three groups of people in relation to students' learning.

The second part will be by interview, to explore some of the issues in depth, and to find out whether different relationships influence the types of knowledge and skills that students need to acquire, to achieve competence to practise.

Questionnaires are being sent to midwife teachers, with recognised qualifications, midwife practitioners, and student midwives. Interviews will be arranged individually. Not everyone who receives a questionnaire will be interviewed.

All information given in both the questionnaire and the interview will be treated in confidence.

Please could you complete the questionnaire by \_\_\_\_\_ and return the completed form to me in the enclosed envelope to the posting place indicated on the enclosed envelope.

On completion of the study a summary will be made available for those who have participated in the research.

I am grateful to you for participating in this study. Thank you very much for your help.

Yours sincerely,

## Communication 5

### Example of letter circulated as a second request to respondents to complete questionnaire

Dear

In the last two months I wrote to ask if you could assist me in undertaking research which enquires about the relationships between the midwife teacher, practitioner and student. With the letter I sent a questionnaire in hope that you would complete this and return it to me.

As yet I have not received your completed questionnaire and I should be grateful if you could do so, in order for me to continue with the study. There are large brown envelopes on each ward or department, with my name on and marked research, into which you can put the completed questionnaire.

If you no longer have the original questionnaire and would still be willing to complete one I enclose one with this letter. I should be grateful if you could complete it. I hope to have all the questionnaires returned by . Please let me know if you need extended time to complete it.

I am extremely grateful to all those who have assisted me in gaining information to make this study.

Thank you for your help,

Yours sincerely,

## Communication 6

### Example of the letter circulated to respondents who agreed to be interviewed.

Dear Colleague,

Thank you for agreeing to be interviewed for the study into relationships between the midwife student, the midwife practitioner and the midwife teacher. In this research I am seeking to explore the nature of these relationships and the extent to which there are different relationships between these three groups, in enabling students to acquire knowledge and skills.

The interview will last approximately one hour, to enable discussion of these issues. I shall be tape-recording the interview, which will remain confidential. I should be grateful if a room could be available where there are no interruptions.

I confirm that the interview will take place:

On

At

Thank you very much for agreeing to participate in this study.

Yours sincerely,

## Appendix 8.

### Questionnaire: Midwife teacher

#### To be completed by Midwife Teachers

All information will be treated in confidence

#### Please complete the following questions

1. How many months/years have you been teaching students since qualifying as a midwife teacher? [            ]
2. In which year did you receive a qualification as a midwife teacher? [            ]
3. What is your teaching qualification?  
.....
4. How many years have you practised as a midwife before employment as a midwife teacher? [            ]
5. In which year did you qualify as a midwife? [            ]
6. Do you currently have a specific commitment to work in the clinical practice area? YES / NO  
If **YES** How many hours approximately per week [            ]  
Please explain commitment \_\_\_\_\_  
\_\_\_\_\_
7. Please describe any contacts you have with **midwife practitioners**?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Please describe any contacts that you have with **student midwives** either in the clinical area or in the education centre?

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9. What do you feel is necessary in good working relationships between **midwife teachers**, and **midwife practitioners** to promote student learning?

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10. What do you feel is necessary in good working relationships between **midwife teachers**, and **midwife students** to promote student learning?

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11. What do you feel is necessary in good working relationships between **midwife practitioners**, and **midwife students** to promote student learning?

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12. What difficulties may there be between midwife teacher, midwife practitioner and midwife students, which could limit progress in a student's learning?

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13. Please rate your perception of the relationship you have with the **midwife practitioners** on the following scale, by drawing a mark on the line.

GOOD	AVERAGE								BAD
1	2	3	4	5	6	7	8	9	10

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14 Please rate your perception of the relationship you have with the **student midwives** on the following scale, by drawing a mark on the line.

GOOD	AVERAGE								BAD
1	2	3	4	5	6	7	8	9	10

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**PLEASE ADD ANY FURTHER COMMENTS ABOUT RELATIONSHIPS AND CONTACTS**

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Thank you very much for completing this questionnaire.

Please return to J Magill - Cuerden

In the brown envelope on the wards and departments:-

marked J. Magill - Cuerden  
Research.

Appendix 9.

Questionnaire: Midwife practitioners

QUESTIONNAIRE

For completion by Midwife Practitioner

All information will be treated in confidence

Please complete the following questions

1. How many years have you been practising as a midwife? [ ]

2. What year did you qualify as a midwife? [ ]

3. Please indicate other professional qualifications that you hold e.g.:-

ENB 997/998 [ ]

Advanced Diploma in Midwifery [ ]

Diploma in Professional Studies [ ]

Other [ ]

please state \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Please describe any contacts you have with **midwife teachers**?

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5. Please describe any contacts that you have with **student midwives**.

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6. What do you feel is necessary in good working relationships between **midwife teachers**, and **midwife practitioners** to promote student learning?

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7. What do you feel is necessary in good working relationships between **midwife teachers**, and **midwife students** to promote student learning?

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8. What do you feel is necessary in good working relationships between **midwife practitioners**, and **midwife students** to promote student learning?

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9. What difficulties may there be between midwife teacher, midwife practitioner and midwife students, which could limit progress in student's learning?

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10. Are you involved in education of student midwives?  
YES / NO

If **YES** please describe in what ways

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11. Please rate your perception of the relationship you have with the **midwife teachers** on the following scale, by drawing a mark on the line.

GOOD	AVERAGE								BAD
1	2	3	4	5	6	7	8	9	10

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12 Please rate your perception of the relationship you have with the **student midwives** on the following scale, by drawing a mark on the line.

GOOD	AVERAGE								BAD
1	2	3	4	5	6	7	8	9	10

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**PLEASE ADD ANY FURTHER COMMENTS**

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Thank you very much for completing this questionnaire.

Please return to J Magill - Cuerden

In the brown envelope on the wards and departments:-

marked J. Magill - Cuerden  
Research.

Appendix 10.

Questionnaire: Students

QUESTIONNAIRE

For completion by Students

All information will be treated in confidence

Please complete the following questions

1. When did you commence your midwifery education programme? [ ]

2. Please state at what stage are you in the programme of midwifery education, in numbers of months? [ ]

3. What type of midwifery education programme are you undertaking ?  
please tick box

Three year Diploma	[	]
Three year Degree	[	]
Eighteen month Degree	[	]
Eighteen month Diploma	[	]
Adaptation programme	[	]
Other midwifery programme	[	]

4. Please describe any contacts you have with **midwife teachers**?

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5. Please describe any contacts that you have with **midwife practitioners**.

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6. What do you feel is necessary in good working relationships between **midwife teachers**, and **midwife practitioners** to promote student learning?

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7. What do you feel is necessary in good working relationships between **midwife teachers**, and **midwife students** to promote student learning?

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8. What do you feel is necessary in good working relationships between **midwife practitioners**, and **midwife students** to promote student learning?

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9. What difficulties may there be between midwife teacher, midwife practitioner and midwife students, which could limit progress in student's learning?

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10. Please rate your perception of the relationship you have with the **midwife practitioners** on the following scale, by drawing a mark on the line.

GOOD	AVERAGE								BAD
1	2	3	4	5	6	7	8	9	10

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11. Please rate the relationship you have with the **midwife teachers** on the following scale, by drawing a mark on the line.



GOOD				AVERAGE						BAD
1	2	3	4	5	6	7	8	9	10	

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PLEASE ADD ANY FURTHER COMMENTS

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Thank you very much for completing this questionnaire.

Please return to J Magill - Cuerden

In the brown envelope on the wards and departments:-

marked      J. Magill - Cuerden  
Research.

**Interview inventory**

**1. Indicators influencing roles and relationships**

1. Personal and professional background and experience
2. View of structured and unstructured links and communication
3. Perceptions of accountability and responsibility in student learning
4. Role in education of students
5. Perceptions of Relationships  
Between Student - Practitioner  
Teacher - Practitioner  
Teacher - Student
6. Perceptions of the effects of mother and baby on relationships
8. Qualities of relationships  
what is one which facilitates learning?  
what is a laissez faire one  
what is one which inhibits learning

**2.View of triad on acquisition of knowledge and skills by students**

8. How relationships affect a student in acquiring knowledge and skills
9. Perceptions of what knowledge students acquire and from whom and their relationships
10. Perceptions of students in the acquisition of skills
11. Perceptions of what skills students acquire from whom and their relationships
12. Expectations of competence / confidence in students
13. Views on where knowledge and skill are acquired

**3. Recognition of values and differences between the triad**

14. Values held of others in student's education
15. Values held by the triad causing conflicts/anxieties.
16. Factors within the triad which inhibit learning by students.

## Appendix 12.

### Interview schedule

Used as guide by interviewer )  
during initial interviews and subsequently  
for note taking)

CODE: \_\_\_\_\_

### **1. Personal Indicators Influencing Roles and Relationships**

#### **SECTION 1**

### **1. Personal and Professional Background and Experience**

1.1. Clarification of questionnaire

1.2. Clarification of formal and informal links- relationships  
- structured and unstructured  
- communication on questionnaire

### **2. Relationships and Accountability**

2.1. What kind of accountability do you have for student midwife learning?

2.2 Does the term accountability differ from responsibility for the student in any way - Can you differentiate?

2.4. What kind of responsibility /accountability do you have for clinical care?

2.5 Does your relationship with the student influence this sense of responsibility - Accountability for the client in clinical care?

### **3. Perceptions of Role in Education of Students**

3.1 What is your role in the education of student midwives?

3.2. What do you see as the teacher/practitioner role?

3.3. What do you see as the student's role?

### **4. Perceptions of Relationships Between Student, Practitioner and Teacher**

4.1. What do you think the relationship should be between ?

the teacher - student ?

the student - teacher ?

the practitioner - student ?

the student - practitioner ?

the teacher - practitioner ?

the practitioner - teacher ?

4.4. Can you describe the characteristics of a good relationship?

Are these characteristics different between:-

teacher - student ?

midwife practitioner - student ?

midwife practitioner - teacher ?

4.5. What do you feel are the characteristics of a bad relationship ?

Do these differ between?

teacher - student

midwife practitioner - student

midwife practitioner - teacher

4.7. Do you feel that the mother or her family influence the relationship - if so in what way?

## **5. Sense of responsibility in relationships of for Students**

5.1 Are there factors which influence relationships within the triad?

5.2. Are there factors which influence your sense of responsibility for education of student midwives?

## **SECTION 2**

### **2.View of Triad on Acquisition of Knowledge and Skills by students**

#### **6. Perceptions of How Students Acquire Knowledge**

6. Can you describe your views of midwifery knowledge?

6.1. How do you feel that students acquire knowledge of midwifery?

6.2. Do you think that there are different kinds of knowledge that the student acquires? please give an explanation

## **7. Perceptions of What Knowledge Students Acquire and from Whom**

7.1 From whom does the student acquire knowledge and does this differ between different people with whom she comes in contact?

7.2 Are there different types of relationships to convey different types of knowledge?  
Examples

## **8. Perceptions of Students in the Acquisition of Skills**

Can you describe what the skills are in midwifery?

8.1 How do you feel that students acquire skills in midwifery?

8.2 Do you think that there are different kinds of skills that the student achieves ? - Please explain give examples

## **9. Perceptions of What Skills Students Acquire from Whom**

9.1 From where, whom and how does the student acquire skills, and are these different skills ?

9.2 Please explain if different relationships are required to convey varied types of skills

## **10. Expectations of Competence/Confidence in Students**

10.1 What expectations do you have of students at the end of the course in?

1. Competence - please give examples to explain what you mean

2. Confidence - please give examples to explain what you mean

10.4 What do you understand by the theory/practice relationship?

10.5 How does the relationship between the triad influence this?

10.6 How does the relationship with the mother and family influence this?

## **SECTION 3 Recognition of Values and Differences between the Triad**

### **11. Values Held of Others in Students Education**

11.1. Do people - explain whom - hold different values for the education of students?



## **12. Values/beliefs held by the Triad:**

Effects of differences held ?

12.1. In what ways do teachers and practitioners hold similar views and values for students' learning ?

12.2 What are the effects of different values for

a. education of students?

b. clinical care?

held by

teacher - student

midwife practitioner - student

midwife practitioner - teacher

## **13. Factors within the Triad which Aid/Inhibit Learning by Students.**

13.1. What are the views on the inter – relationship aiding/inhibiting learning knowledge and acquisition of :-

skills by students ?

13.2 Within the relationship of the triad are there issues which cause conflict, or inhibit learning - if so please explain?

14. Any final comments

## **Appendix 13.**

### **Analysis of teachers' questionnaires: Emergence of themes**

**Phase Two: Teachers questionnaires following analysis (first level analysis) identifying codes and clustering codes into categories.**

#### **Contacts between teachers and practitioners**

##### **1. Structured Contacts**

Meetings - with managers  
- ward meetings  
- unit meetings  
Auditing clinical learning environment  
Interviewing for new members of clinical staff

##### **2. Teaching commitments**

Clinical teaching  
Continuing and post basic education sessions

##### **3. Educational support of clinical staff**

Mentor support  
Advise on assessing/counselling

##### **4. Giving students support in clinical area**

Working with students  
Visiting areas to see students

##### **5. Personal support of staff**

As a colleague  
'Shoulder to lean on'  
Working alongside staff  
Socialising

#### **Contacts between teachers and students**

##### **1. Teaching on course programmes**

Teaching sessions  
Personal tutorials  
Participating in study sessions

##### **2. Personal tutor**

Site link responsibility  
Regular working with students in clinical area

### **3. Personal support**

Advice and guidance  
Counselling re-theory/practice / pastoral  
Dealing with personal problems  
'Trouble shooting'  
Help in projects

## **Qualities of a good working relationship between teachers and practitioners to promote student learning**

### **1. Personal characteristics**

Sense of humour  
Share with others  
Approachability  
Accessibility  
Empathetic

### **2. Interpersonal skills**

Communication  
Listener  
Negotiator

### **3. Personal and professional knowledge**

Demonstrates direct experience

### **4. Educational skills/ability**

Keeps practitioner informed  
Gives advice/support  
Shares knowledge  
Educates clinician  
Is a resource

### **5. Clinical skills / credibility**

Recognises limits of role  
Able to work as a clinician  
Seen in clinical area

### **6. Value each other**

Recognise each other's stresses

Mutual respect for each other  
View each other with complementarity  
Realistic about each other's role

### **Qualities of a good working relationship between teacher and student**

#### **1. Personal characteristics**

Openness  
Enthusiasm  
Honesty  
Humour  
Trust in student

#### **2. Interpersonal skills**

Communicates effectively

#### **3. Personal and professional knowledge**

Acts as resource  
Gives good feedback

#### **4. Educational skills/ ability**

Is a role model  
Available  
Recognises student needs

#### **5. Clinical skills /ability/credibility**

Teacher is clinically credible  
Teacher is seen as a practitioner

#### **6. Values each other**

Mutual respect  
Shows interest in the student  
Respects student as an adult learner

#### **7. Relates theory to practice**

#### **8. Structure and organisational**

#### **9. Other**

#### **10. Difficulties encountered**

### **Qualities of good working relationships between midwife practitioners and students**

### **1. Personal characteristics**

Personalities complement each other  
Build up a good rapport  
Openness  
Enthusiasm  
Motivated  
Friendly body language  
Honesty  
Closeness, happiness  
Able to enjoy each other

### **2. Interpersonal skills**

Good communication

### **3. Personal and professional knowledge**

Admitting when you do not know  
Knowledge of the curriculum and assessment  
Acts as a role model  
Demonstrate professional standards

### **4. Educational skills/ ability**

Enjoys teaching  
Using every opportunity to teach  
Good mentorship re- continuity of care  
  
Same off duty  
Makes time for teaching student  
Encourages the student to reflect

### **5. Clinical skills / ability**

Up to date with practice  
Analyses practice with student

### **6. Value each other**

Recognises pressures  
Provides a supportive environment

### **7. Relates theory to practice**

### **8. Structure and organisational**

## **9. Other**

## **10. Difficulties**

### **Difficulties in relationships**

#### **1. Personal characteristics**

Students' expectations too high  
Expectations too high or different

#### **2. Interpersonal skills**

Rigid and dogmatic behaviour  
Too much mothering

#### **3. Knowledge and skills**

Lack of confidence in ability  
Ignorance of curriculum/training programme/assessments  
Poor understanding of research

#### **4. Education**

Lack of keeping up to date  
Not giving time to students

#### **5. Theory and practice**

Conflicting information given between  
Lecturer and practitioner  
Incongruence between theory and practice

#### **6. Value each other**

Overwork and overstress  
Unrealistic about pressures  
Failure to appreciate pressures  
Failure to recognise each other's role

#### **7. Structure and organisation**

#### **8. Divergent areas**

Difference between philosophy and aims and values  
Lack of time

## **Appendix 14.**

### **Analysis of practitioners' questionnaires: Emergence of themes**

#### **Phase Two: Practitioners' questionnaires following analysis (first level analysis) coding and clustering into categories**

##### **Contacts between teachers and practitioners**

###### **1. Structured contacts**

Meetings - with managers  
    - ward meetings occasionally  
    - unit meetings  
Meetings for curriculum and examination boards  
Auditing clinical learning environment  
Interviewing for new members of clinical staff

###### **2. Teaching commitments**

Clinical teaching  
Continuing and post basic education sessions  
Mentoring students on post registered courses  
at study days

###### **3. Educational support of clinical staff**

Mentor support  
Advise on assessing/counselling  
Obtaining advise on research  
Discussion on quality

###### **4. Giving practitioners support in clinical area**

Working with students  
Visiting areas to see students  
Working occasionally in ward areas

###### **5. Personal support of practitioners**

Usually helpful  
I visit the school when I need help

###### **6. None or minimal contact**

No contact at all  
Hardly ever see one/very infrequent  
Do not need to see one  
Little contact since qualifying

## **7. Problems seen with contacts**

“Difficult now as the teachers are on different sites” *m/w qual 20yrs.*

“When I first qualified midwife teachers had more of a clinical role”  
*m/w qual 17 yrs.*

## **Contacts between practitioners and students**

### **1. Daily work**

Regularly every day - personal contact  
Work closely together every day and all day  
Working on the wards

### **2. Personal mentor**

Mentor support - personal to students  
Mentoring on a regular basis  
Finding out what the student wants

### **3. Personal support**

Advice and guidance  
Working alongside the students  
Discussing work  
Giving support

### **4. Other**

Sorting out problems  
Sorting out allocation  
Ward teaching

## **Qualities of a good working relationship between teachers, and practitioners to promote student learning**

### **1. Personal characteristics**

Open mindedness  
Sense of humour  
Approachability  
Accessibility  
Work as a member of the team  
Demonstrate and have the ability to ask questions of the teacher



## **2. Interpersonal skills**

Communication

Be able to discuss problems

Constantly liaise with each other

Support in a stressful time

Personal differences should not interfere with communication

## **3. Personal and professional knowledge**

Keep up to date with professional knowledge

## **4. Educational skills/ability**

Keeps practitioner informed

More information about the curriculum

Wish to agree on the curriculum

Practitioner should be well informed about the students' objectives

Teachers need to assist staff to keep up standards

## **5. Clinical skills / credibility**

Demonstrate credibility clinically

Keep up to date with professional knowledge and practice

Like to see tutors working more in clinical areas

## **6. Value each other**

Mutual respect for each other

Recognises each other's role

Realistic about each other's role

No conflicting ideas

Have common values

Like more contact with the teachers

## **7. Relates theory to practice**

What is taught in classroom must be what is taught in practice

To be at one with everything

Make sure information is not contradictory

## **8. Structure and organisation**

Regular informal contact

Access to each other

## **9. Other**

Would like more contact  
Would like more feedback particularly on personal students

## **10. Incidental**

Student must be willing to learn  
Teachers need to work in a team

## **Qualities of a good working relationship between teacher and student**

### **1. Personal characteristics**

Enthusiasm  
Inspiration inspires a student to learn  
Humour  
Trust in student  
Approachable  
Accessible  
Respects confidentiality  
Gives time  
Sensitivity

### **2. Interpersonal skills**

Communicates effectively  
Compatible personalities  
Good rapport  
Available  
Positive and enthusiastic

### **3. Personal and professional knowledge**

Constantly re-iterating information  
Gives freedom to let student try  
Recognises changing culture of nursing and midwifery  
Aware of current changes in practice

### **4. Educational ability / skills**

Recognise students learning strategies  
Give small group teaching  
Give more ward-based teaching  
To be able to identify students' needs  
Enable students to plan their curriculum  
Recognise students' needs  
To identify their needs

## **5. Clinical credibility / ability / skills**

Teacher should work with students  
Need to bridge the theory/practice gap  
Teacher should have clinical commitments

## **6. Value each other**

Mutual respect  
Trust each other  
Understanding each other's roles  
Respect each other's roles  
Not to diminish students' confidence  
Teachers to support students

## **7. Relates theory to practice**

Relates theory to practice

## **8. Structure /organisational**

Gives time  
Easy access to each other  
Makes regular contact

## **9. Other**

Teachers to sort out what students don't understand  
Give feed back on progress  
Spot potential problems earlier

One general comment from m/w "It is good so far!"

## **Qualities of good working relationships between midwife practitioners and students**

### **1. Personal characteristics**

Personalities complement each other  
Openness  
Enthusiasm  
Motivated  
Honesty  
Closeness, happiness  
Able to enjoy each other  
Approachability  
Giving confidence  
Praise and caution  
Be sensitive  
Taking initiative

## **2. Interpersonal skills**

- Good communication
- Verbal and example
- Good listener
- Not talking down to student
- Student recognises stresses of staff
- Understanding each others commitments and each other
- Good team work in caring for clients

## **3. Personal and professional knowledge**

- Good practical knowledge
- Up to date
- Consistency in advice
- Up to date with the students' programme
- Up to date with research
- Knowledge of the curriculum and assessment
- Acts as a role model
- Practitioner is knowledgeable in demonstrating techniques in subjects and skills
- Provide a good learning experience

## **4. Educational ability / skills**

- Makes time for teaching student
- Willingness of the students to learn
- Flexibility of learning needs
- Identify student's needs
- Not a threatening experience
- Know aims and objectives
- Student to give clear idea to practitioners what they need
- To cover for their period of the programme

## **5. Clinical credibility /skills / credibility**

- Being realistic about students

## **6. Value each other**

- Respect each other and their abilities
- Recognises pressures
- Provides a supportive environment
- Gives the student time to reflect
- Mutual support

## **7. Relates theory to practice**

## **8. Structure and organisational**

- Be available
- Offer time to discuss
- Regular meetings
- Time
- Safe environment for learning
- Contact working 2-3 times a week
- Work consistently with student to develop a relationship
- Make time at the beginning and the end of the programme
- Involve manager

## **9. Other**

### **Difficulties in relationships**

#### **1. Personal characteristics**

- Clash of personality
- Inability to maintain confidentiality

#### **2. Interpersonal skills**

- Lack of communication
- Inability to communicate

#### **3. Personal and professional knowledge**

- Midwife out of date and relies on past experiences
- Practitioners who will not update themselves
- Different expectations
- Conflicting information given between lecturer and practitioner
- Lack of emphasis of anatomy and physiology - makes it difficult for clinical teaching
- Lack of emphasis of maternity care

#### **4. Educational ability /skills**

- Practitioners who do not recognise education as part of their role
- Inconsistency in teaching
- Lack of recognition of students needs
- Mismatch of information between school and practice
- Poor exchange of knowledge between teachers and practitioners
- Poor information about training - none!

#### **5. Clinical skills / ability /credibility**

#### **6. Value each other**

- Differences between student and practitioners

When there is no time to assess  
Not valuing each other  
Lack of respect from the student  
Lack of student understanding stresses in clinical area  
Lack of appreciation of teacher of clinical situation  
Lack of support  
Poor understanding of each other's role  
Lack of insight into each other's problems and role  
There is a threat of a junior (student) with more life experience  
Lack of understanding of stresses  
Students not adjusting to being students

#### **7. Relate theory to practice**

Conflicting advice  
Lack of shared objectives

#### **8. Structure and organisation**

Having a mentorship scheme which does not enable contact  
Poor allocation

#### **8. Other**

Pressure on students owing to assignments  
Different expectations

#### **Other comments:**

Limited contact with teacher on a regular or official level

Lecturers approachable

Midwife teachers being on other sites difficult to reach and contact

Personality of a student should not necessarily influence the teacher's perception of competence as a prospective midwife

Do not believe all clinical teaching should be put onto the practitioners

Other stresses - including teaching several other grades:  
                                  medical students,  
                                  doctors  
                                  nurses

Teachers should be more involved themselves in teaching students that is clinically.

Learning environment and problem solving

**Analysis of Students' Questionnaires - Emergence of themes**

**Phase Two: Students' questionnaires following initial analysis -**

**1. Contacts between Teachers and Students**

**1. Structured Contacts**

Visits to teacher when assignments are due  
for marking  
see teacher every three to four months

In the classroom - not clinically  
When attending lectures

**2. Teaching Commitments**

Meet occasionally outside lectures  
Standard of teacher very variable  
Some are very well prepared and others are not

**3. Educational Support of Students**

Personal tutorials  
Small group teaching  
Relating theory to practice  
Personal tutors with appointments  
With assignments - formative development  
With assignments - general guidance

**4. Giving Students Support in Clinical Area**

In clinical area x1 per allocation  
Occasionally  
Contact initially in the programme though later diminished

**5. Personal Support of Students**

On a one to one basis  
Times of personal crisis

## **Contacts between Practitioners and Students**

### **1. Structured Contacts**

Working closely in the clinical setting  
in the      Antenatal wards  
              Post natal wards  
              Delivery suite  
              Community

Work with / Supervised by /  
Taught by / Discussed with

### **2. Personal Responsibility / Mentoring**

worked with a mentor / helps to have a mentor  
Mentor system works well in hospital and community  
Working with a mentor who is qualified midwife  
Continually in contact with the mentor system

### **3. Personal Support**

Personal contact outside unit and personal friendships  
with midwives  
Social contacts

### **4. Educational**

Taught and helped enormously  
Gained most from the practitioner  
Occasional teaching session  
Assessments completing  
Use other midwives as a source of information  
Very little worked only one day a week with a practitioner

### **Other**

Auditing the clinical area and the learning environment

## **Qualities of a Good Working Relationship Between Teachers, Practitioners to promote student learning**

### **1. Personal Characteristics**

Friendship  
Helping students to reflect on how they felt  
Supporting students  
Understanding



## **2. Interpersonal Skills**

- Communication
- Freely and openly discuss
- To be listened to - enable clarification
- Promotion of self-esteem in others

## **3. Personal and Professional Knowledge**

- Prevents conflicting advice
- Not leave students to convey information
- Need to work together to avoid overlapping
- Know expectations of each other's role

## **4. Educational Skills/Ability**

- Feedback on performance to students
- Explain allocations, curriculum, assessments
- Teachers need to help practitioner to teach students
- Ensure classroom theory relates to practice
- More study days to keep practitioners up to date
- Require more teaching sessions of practitioners
- Keep practitioner up to date with assessments

## **5. Clinical credibility /ability / skills**

- Making sure practitioners are up to date
- Have a good knowledge of Midwifery

## **6. Value each other**

## **7. Relates Theory to Practice**

## **8. Organisational**

- Continuous contact to prevent conflicting advice

## **9. Other**

Students take what information they need from others

One student during 11 months of her course had never seen a tutor in the clinical area

Never seen a teacher communicate with a practitioner on any aspect of student learning expect to demonstrate skills

One student puts the complexity of a large group over many sites as a problem with relationships between practitioners and teachers. Also indicates that this causes

different relationships with the student. She felt that it was a duty for the student to meet with the tutor and that the onus is on the student to make the contact with the tutor.

### **Qualities of a Good Working Relationship Between Teacher and Student**

#### **1. Personal characteristics**

- Be available to students
- Approachable
- Friendly - on first name terms
- Promote self-esteem in the student
- Teachers and students to be: Punctual
- Reliable
- Committed

#### **2. Interpersonal skills**

- Recognise the student as an adult
- Negotiate with the student
- Communication - good
- Clear and effective
- Listen to students
- Give constructive criticism and willing to take and accept comments back

#### **3. Personal and Professional Knowledge**

- Give good grounding in midwifery in basics of midwifery
- Knowledge

#### **4. Educational skills / ability**

- Provide effective teaching
- Provide education for the students' level of the programme

#### **5. Clinical credibility ability/ skills**

- Work in the clinical setting
- Important to see the teachers in the clinical settings

#### **6. Value each other**

- Teachers to give advice but not be in conflict with each other
- Understand each other's role

#### **7. Relate theory to Practice**

## **8. Organisation/Structural**

- Continuous contact
- Make contacts outside classroom hours
- Make contacts when there are not only problems
- Make student feel she is known
- (Suggested that groups are smaller and that teachers have responsibility for small number of students only)

## **Other Comments**

Students take what information they need from others

## **Qualities of Good Working Relationships between Midwife Practitioners and students**

### **1. Personal Characteristics**

- Friendship and understanding
- Personally work well
- Made to feel at ease together and welcome
- Interest in you personally
- Trust and understanding on both sides
- Giving responsibility and letting go

### **2. Interpersonal skills**

- Good communication
- Clear concise information
- Able to praise and give constructive criticism

### **3. Personal and Professional Knowledge**

- Accountability
- Gain most knowledge from clinical practitioners
- Up to date knowledge

### **4. Educational skills / ability**

- Has teaching skills
- Able to discuss constructively to students
- Completes assessments as required
- Knowing the level of training of the student
- Knows mentor role and can go to her for support

## **5. Clinical credibility /ability /skills**

Midwife committed to client care

## **6. Value each Other**

Giving support

## **7. Relates theory to Practice**

## **8. Organisational and Structure**

Regular contact

Work closely with practitioners

Planning and organising what the student needs

Allocating students to work independently gives them confidence

## **9. Other**

Student must want to learn

The learning environment must be appropriate.

## **Difficulties in Relationships**

### **1. Personal characteristics**

Personality clashes

Students expect too high standards

Open criticism of teachers and practitioners by each other

Teachers' expectations too high

Teachers' expectations too low

Different personalities

### **2. Interpersonal Skills**

Communication skills lacking

### **3. Personal and Professional Knowledge**

Depth of knowledge lacking

Poor knowledge

Overlapping information and repetition

Lack of knowledge

Conflicting information given between lecturer and practitioner

#### **4. Educational skills / ability**

- Lectures out of date with practice
- Theories given versus realities
- Teachers being out of date
- Teaching below the standard the student is at
- Poor teaching skills

#### **5. Clinical skills / ability / credibility**

#### **6. Value for each other**

- Not understanding role
- Students constantly being late

#### **7. Relates Theory to Practice**

#### **8. Structure and Organisation**

- Being mentored by a newly qualified midwife = negative
- There is a need to choose mentors carefully
- People being placed on different sites
- Difficult to get hold of
- Staffing levels
- Time

#### **9. Other**

- Inability of the student to apply learning
- Reaching for perfection
- Practitioners work with student constantly whereas the Teacher does not

#### **10. Divergent areas**

- Differences of opinion
- Different information being given

**Summary of themes in questionnaires (initial coding)**

***Analysis - Emergence of Themes (summary)***

**SUMMARY OF CORE CATEGORIES IN QUESTIONNAIRES**

**1. Contacts**

1.1. Structured contacts

1.2. Teaching commitments

1.3. Educational support

1.4. Clinical support

1.5. Personal support

**2. Working Relationships**

2.1. Personal characteristics

2.2. Interpersonal skills

2.3. Personal and professional knowledge

2.4. Educational skills/ ability

2.5. Clinical skills / ability / credibility

2.6. Value each other

2.7. Relates theory to practice

2.8. Structure and organisational

2.9. Other

**Themes emergent from the analysis of interviews**

**Phase Two: Codes for interviews - first level analysis**

**1. Organisational factors influencing relationships**

- 1.1. Formal contacts
- 1.2. Informal contacts
- 1.3. Other types of contacts
- 1.4. Time for meeting
- 1.5. Seeing and talking

**2. Accountability characteristics**

- 2.1. Practitioners to students
- 2.2. Teachers to students
- 2.3. Practitioners to teachers
- 2.4. Students to teachers
- 2.5. Teachers to practitioners
- 2.6. Students to practitioners

**3. Responsibility characteristics**

- 3.1. Practitioners to students
- 3.2. Teachers to students
- 3.3. Practitioners to teachers
- 3.4. Students to teachers
- 3.5. Teachers to practitioners
- 3.6. Students to practitioners

**4. Relationships for accountability**

- 4.1. Practitioners to students
- 4.2. Teachers to students
- 4.3. Practitioners to teachers
- 4.4. Students to teachers
- 4.5. Teachers to practitioners
- 4.6. Students to practitioners

**5. Relationships for responsibility**

- 5.1. Practitioners to students
- 5.2. Teachers to students
- 5.3. Practitioners to teachers
- 5.4. Students to teachers
- 5.5. Teachers to practitioners
- 5.6. Students to practitioners

**5.7. Differences between accountability and responsibility**

**6. Role in relationship to:**

- 6.1. Practitioners to students
- 6.2. Teachers to students
- 6.3. Practitioners to teachers

- 6.4. Students to teachers
- 6.5. Teachers to practitioners
- 6.6 Students to practitioners

**7. Influence of client on relationships**

- 7.1. Positive
- 7.2. Negative
- 7.3 Other

**8. Influence of others on relationships**

**9. Characteristics of a learning relationship**

- 9.1. Personal
- 9.2. Professional
- 9.3. Knowledge
- 9.4. Educational
- 9.5. Other

**10. Characteristics of a relationship when learning does not take place**

- 10.1. Personal
- 10.2. Professional
- 10.3. Knowledge
- 10.4. Educational
- 10.5. Other

**11. Types of knowledge and differing relationships**

- 11.1. Interpersonal
- 11.2. Midwifery
- 11.3. Sciences
- 11.4. Personal
- 11.5. Theoretical
- 11.5. Practical

**12. Relationships assisting acquisition of knowledge**

- 12.1. Loose
- 12.2. Close
- 12.3. Other

**13. Types of skills to be acquired**

- 13.1. Manual skills
- 13.1. Using all senses
- 13.3. Interpersonal skills
- 13.4. Intimate care

**14. Relationships assisting acquisition of skills**

- 14.1. Factors which influence
- 14.2. Factors which do not affect acquisition
- 14.3. Factors which negate learning acquisition of skills



**15. Types of relationships affecting students “competence” to practice at levels  
Of training**

- 15.1. Positive
- 15.2. Negative
- 15.3. Active
- 15.4. Passive
- 15.5. Other

**16. Relationships affecting confidence**

- 16.1. Characteristics which promote confidence in learning
- 19.2. Characteristics which negate confidence in learning

**17. Conflicts in relationships.**

- 17.1. Personality conflicts
- 17.2. Professional divergence

**18. Relationships and theory practice relates v non relates**

- 18.1. Relationship characteristics of those which relate
- 18.2. Relationship characteristics of those which do not relate

**19. Educational Issues**

- 19.1. Relationship characteristics which promote learning
- 19.2. Relationship characteristics which do not promote learning

**20. Boundaries of relationships between teachers, practitioners and students**

- 20.1. Boundaries of relationships between teachers and students
- 20.2. Boundaries of relationships between teachers and practitioners
- 20.3. Boundaries of relationships between practitioners and students

**21. Other**

## Appendix 18.

### Frequency of response - an example of encounter Frequency of concept raised by sample groups on questionnaires

Types of encounters made in relationship between teachers, practitioners and students

Type of encounter	Teachers	Practitioners	Students
Meetings: examples are: curriculum. programme planning assessment	3	1	0
Auditing clinical areas	3	1	0
Interviewing	3	0	0
Teacher/classroom contact	3	1	3
Clinical teaching contact	3	0	0
Visiting clinical area	3	1	1
Visiting classroom	0	0	2
Personal support	1	1	1

Key to numbers:

- 0 = not mentioned by sample group
- 1 = mentioned by some
- 2 = mentioned by most
- 3 = mentioned by all

Summary of responses from 191 questionnaires of open

## Appendix 19

questions showing percentage of responses themes analysed per component with elements

### Total Number of Responses

Total Number of Responses		191		191		191		573	
		t/p		p/s		t/s		total	
<b>Personal traits</b>									
Respect for each other		89	47%	74	39%	62	32%	225	39%
Trust in others		41	21%	71	37%	46	24%	158	28%
Honesty*			0%	34	18%	36	19%	70	12%
Reliability*		20	10%	25	13%	34	18%	79	14%
Consistency in behaviour and attitude*		34	18%	32	17%	42	22%	108	19%
Maintaining Confidences*		16	8%	20	10%	28	15%	64	11%
Having self confidence		12	6%	24	13%	18	9%	54	9%
<b>Social and communications abilities</b>									
Ability to communicate		131	69%	102	53%	91	48%	324	57%
Verbal communication		52	27%	37	19%	59	31%	148	26%
Able to listen		46	24%	39	20%	35	18%	120	21%
Responsive in teamwork		19	10%	31	16%	24	13%	74	13%
Social responses to others		14	7%	43	23%	23	12%	80	14%
<b>Personal Knowledge:</b>									
People knowledge		39	20%	52	27%	37	19%	128	22%
Receptivity to others		21	11%	29	15%	33	17%	83	14%
Showing friendship		33	17%	63	33%	51	27%	147	26%
Knowing the boundaries of friendship		10	5%	30	16%	29	15%	69	12%
<b>Professional Knowledge</b>									
Knowledge of Midwifery		34	18%	58	30%	42	22%	134	23%
Clinical practice skills		50	26%	58	30%	43	23%	151	26%
Research Awareness		34	18%	53	28%	31	16%	118	21%
<b>Vision for practice</b>									
Similar goals for practice		42	22%	50	26%	24	13%	116	20%
Practitioners to communicate beliefs/standards		70	37%	58	30%	33	17%	161	28%
Teachers to communicate beliefs/standards		33	17%	45	24%	20	10%	98	17%
<b>Educational ability:</b>									
<u>Teacher</u>	Links theory and practice	63	33%	53	28%	66	35%	182	32%
	Uses clinical skills	48	25%	24	13%	58	30%	130	23%
	Provides feedback	30	16%	21	11%	37	19%	88	15%
	Teaching and education skills	36	19%	21	11%	36	19%	93	16%
<u>Practitioner</u>	Teaching and education skills	40	21%	65	34%	24	13%	129	23%
	Provides feedback	23	12%	24	13%	15	8%	62	11%
	Knowledge of the curriculum	49	26%	63	33%	29	15%	141	25%
	Knowledge of the assessments	39	20%	45	24%	22	12%	106	18%
<u>Student</u>	Recognises learning objectives	14	7%	29	15%	17	9%	60	10%
	Eager and motivated to learn	17	9%	31	16%	16	8%	64	11%
	Understands and accepts student's role	30	16%	36	19%	29	15%	95	17%

\* codes grouped together

This analysis has grouped all the responses totalling 191 to gain a total of the three groups

t/p = teacher/practitioner relationship p/s = practitioner/student relationship t/s = teacher/student relationship

# **Types of encounters which occurred between teachers, practitioners and students**

The tables in this appendix summarise the data of formal meetings and contacts which occur between the three sample groups and which was drawn from the data collected on the questionnaires. This was a response to an open question about contacts which occurred and therefore the numbers offer an indication of the encounters, rather than full details of all available formal encounters which could have taken place. The percentages relate to the number in each group who indicated the type of contact.

## **Tables in the appendix:**

- 9.1. Encounters between teachers and students
- 9.2. Encounters between teachers and practitioners
- 9.3. Encounters between practitioners and students

Table 1. Indicates the types of formal meetings between teachers and students.

**Table 1. Encounters between Teachers and Students**

Type of Contact	Percentage response of 23 Teacher Questionnaires	Percentage response of 44 Student Questionnaires
Personal Tutor Role	6	25
Classroom Teaching	50	35
Personal Support	33	22
Clinical Teaching	17	25
Visiting The Clinical Areas	22	16
Clinical Practice	-	6
Minimal support	-	3

Note: Multiple responses were given to the open questions, therefore figures are more than 100%

Table 2. Indicates the types of formal meetings between teachers and practitioners

**Table 2. Encounters between Teachers and Practitioners**

Type of contact	Percentage response of 23 Teacher Questionnaires	Percentage response of 124 Practitioner Questionnaires
Staff Development and Training	61	29
Personal Contact – re-teaching student role	67	21
Classroom Teaching	44	5
Visiting the Clinical Area	50	14
Unit Meetings	33	11
Curriculum Meetings	27	7
Teachers Clinically Teaching	22	6
Auditing	6	3
Interviewing	17	3
Minimal Contact	-	23
No Contact	-	4

Note: Multiple responses were given to an open question, therefore figures are more than 100

Table 3. Indicates the types of formal meetings between teacher and students

**Table 3. Encounters between Practitioners and Students**

Type of Contact	Percentage response of 124 Practitioner Questionnaires	Percentage response of 44 student Questionnaires
Mentor / Preceptor Role	55	96
Clinical Teaching	3	3
Contact, but not Mentor/Preceptor role	26	-

Note: Multiple responses were given to an open question therefore figures are more than 100.

